California Department of Mental Health Community Stakeholder Summer

Draft Summary Report

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Prepared by Eileen Jacobowitz, EJC Consulting and
the California Institute for Mental Health (CIMH)
for the
California Department of Mental Health

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Executive Summary

During the summer of 2011, the California Department of Mental Health conducted a series of community mental health stakeholder meetings to gather input from mental health stakeholders regarding changes to state level mental health functions resulting from recent legislative changes and the 2011-2012 Governor's Budget May Revision.

Over the course of the DMH Stakeholder Summer, the Department heard from hundreds of consumers, family members, private providers, county representatives, local and state level consumer groups, and county organizations. The feedback has been categorized into five overarching themes:

1. Concerns Regarding State Level Mental Health
2. Benefits and Challenges of Local Control
3. Importance of Cultural Competence Leadership and Reducing Disparities
4. Integrity of the Mental Health Services (MHSA) Act
5. Role of Mental Health Consumers and Their Families

The findings related to each of the categories are summarized below. The sections that follow provide a detailed description of the Community Mental Health Stakeholder process including process planning, design, outreach and participation rates, as well as the stakeholder themes supported by participant's quotes.

1. Concerns Regarding State Level Mental Health

- State level executive leadership for community mental health is essential.
- To ensure system integrity and accountability, a state oversight function for both fiscal and program delivery is important.
- Program evaluation and quality improvement are essential functions.
- Stakeholders hope that mental health will have equal "footing" with physical health and position the state for national healthcare reform.
- There are advantages to integrating mental health and alcohol and other drugs, as long as they do not become the "step children" in the public health system.

- There is support for a single state organization responsible for behavioral health.
- The integration of mental health and alcohol and drug programs presents an opportunity to focus on co-occurring disorders.
- It is essential to ensure that mental health expertise is not lost with the shifting of mental health functions away from DMH.
- Many stakeholders were concerned about the current low number of DMH staff due to the transfer of Medi-Cal staff/functions to DHCS.
- Many stakeholders expressed support for maintaining the Department of Mental Health.

2. Benefits and Challenges of Local Control

- Many stakeholders see a larger role for local Mental Health Boards and Commissions and an opportunity for more responsive planning.
- There is hope for relief from some of the current bureaucracy including streamlined reporting requirements and centralized audit activities.
- There is a desire for improved data access.
- Stakeholders see changes at the state level as an opportunity for new rules that remove barriers to services.
- Some stakeholders expressed concerns that local staff may not have the adequate financial experience and resources to effectively manage the complexities of MHSA programs.
- In general, stakeholders want to ensure there is local accountability.
- Many stakeholders expressed apprehension that a shift to local control will result in inequities and/or redirection of funds.
- Do not lose the benefits of "statewideness" including outcome reporting and sharing of best practices.

3. Importance of Cultural Competence Leadership and Reducing Disparities

- Cultural competence and reducing disparities are high priorities.
- Stakeholders want state leadership for cultural competence at the highest level in a state department.

4. Integrity of MHSA

- Do not undo the achievements of MHSA as a result of current realignment efforts.
- Continue to focus on wellness, recovery, and resilience.
- Continue to strive toward an integrated service experience for consumers and family members; avoid fragmentation at all costs.
- Do not lose focus on prevention and early intervention.

5. Role of Mental Health Consumers and Their Families

- Mental health stakeholders are concerned that their existing power will be lost in the realigned mental health system.
- Stakeholders also see the changes as an opportunity for new voices to be heard about ways to improve delivery of local mental health services.

Introduction and Background

The administration of community mental health programs in California is undergoing significant change. The 2011-12 State budget and associated trailer bills, Assembly Bills 102 and 106, authorized the transfer of all Medi-Cal functions to the California Department of Health Care Services (DHCS), realigned Medi-Cal Specialty Mental Health from the state to counties, and significantly changed the state's responsibility for administering the Mental Health Services Act (MHSA) (Assembly Bill 100). Additionally, the 2011-2012 Governor's Budget May Revision proposes eliminating the Departments of Mental Health (DMH) and Alcohol and Drug Programs (ADP). The proposed elimination of DMH and ADP is scheduled to occur in the 2012-13 fiscal year.

In addition to the proposed elimination of DMH, changes required by Assembly Bill 100 and other legislative actions:

- Eliminate state level review and approval of county plans and expenditures by DMH and the Mental Health Services Oversight and Accountability Commission (MHSOAC);
- Replace DMH with the "State" in the distribution of funds from the Mental Health Services fund and the development of regulations necessary to implement MHSA;
- Replace DMH with the MHSOAC as having a possible role in providing technical assistance to county Mental Health Plans;
- Reduce the amount available from revenues deposited in the Mental Health Services fund for State administration from up to 5% to 3.5%; and
- Reduce DMH staff positions from 114 to a total of 19 MHSA funded positions.

In light of these significant changes, during the summer of 2011, DMH convened a series of community mental health stakeholder meetings throughout the state. The meetings were designed to inform stakeholders about the changes to state level mental health administration and to listen to ideas, input, and concerns regarding DMH non-Medi-Cal activities and programs. This report describes the stakeholder process including meeting design and participation levels and summarizes the information gathered during the meetings. The report appendices include materials distributed at the stakeholder meetings, meeting notes, as well as formal feedback and recommendations provided to DMH by mental health stakeholder organizations.

Community Mental Health Stakeholder Process Overview

Process Goals and Purpose

Before embarking upon the stakeholder process, the California Health and Human Services Agency (CHHS) and DMH leadership, in partnership with ADP and DHCS established the following goals for the process:

- Create a fully-inclusive stakeholder participation process;
- Communicate clearly about current state DMH re-organization;
- Educate stakeholders about the role, responsibilities, and resources for the DMH;
- Support efficiency and effectiveness for the community mental health system; and
- Develop a summary report in time for Governor's Budget consideration.

The purpose of the Community Mental Health Stakeholder Meetings was to:

- Gather stakeholder input on future functions and program responsibilities;
- Determine appropriate organizational placement of functions; and
- Define community mental health roles/responsibilities.

Guiding Principles for Stakeholder Input

CHHS and DMH leaders established guiding principles that would inform the stakeholder process. The MHSA General Standards, listed below, have guided planning, decision-making, and the provision of mental health services since the passage of the Act. Department leadership recognize that these General Standards should continue to inform all activities associated with mental health services, including realignment of state mental health functions.

- Community collaboration
- Client and family-driven
- Cultural competence
- Wellness, recovery, and resilience focused
- Integrated services experience

CHHS and DMH leaders also developed specific guiding principles for stakeholder recommendations and asked that stakeholders consider these guiding principles when providing input as part of the Community Mental Health Stakeholder process. The guiding principles are:

- Improve access to culturally appropriate services;
- Improve quality of care;
- Improve state accountability and outcomes;
- Improve efficiency and effectiveness of community mental health system;
- Include realistic implementation strategies taking into consideration available resources; and
- Fulfill organizational/policy/legal/statutory responsibilities.

Stakeholder Process Planning, Design, and Outreach

To achieve its goal of creating an inclusive stakeholder process, DMH actively engaged numerous partners and stakeholder groups to plan, design, schedule, and market the Community Mental Health Stakeholder Process. The table below (Table 1) includes the organizations and entities that were consulted in the planning, process design, materials development, education, outreach and communication activities.

Table 1 Organizations/Entities Involved in Planning

State Partners	County Partners	Community/Advocacy Partners
• California Department of Alcohol and Drug Programs (ADP) • California Department of Health Care Services (DHCS) • California Health and Human Services Agency (CHHS) • California Mental Health Planning Council (CMHPC) • Mental Health Services Oversight and Accountability Commission (MHSOAC)	• California Mental Health Directors Association (CMHDA) • California Association of Local Mental Health Boards and Commissions (CALMHBC) • Workforce Education and Training Regional Partnerships	• California Network of Mental Health Clients (CNMHC) • National Alliance on Mental Illness (NAMI) - California • Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) • United Advocates for Children and Families (UACF)

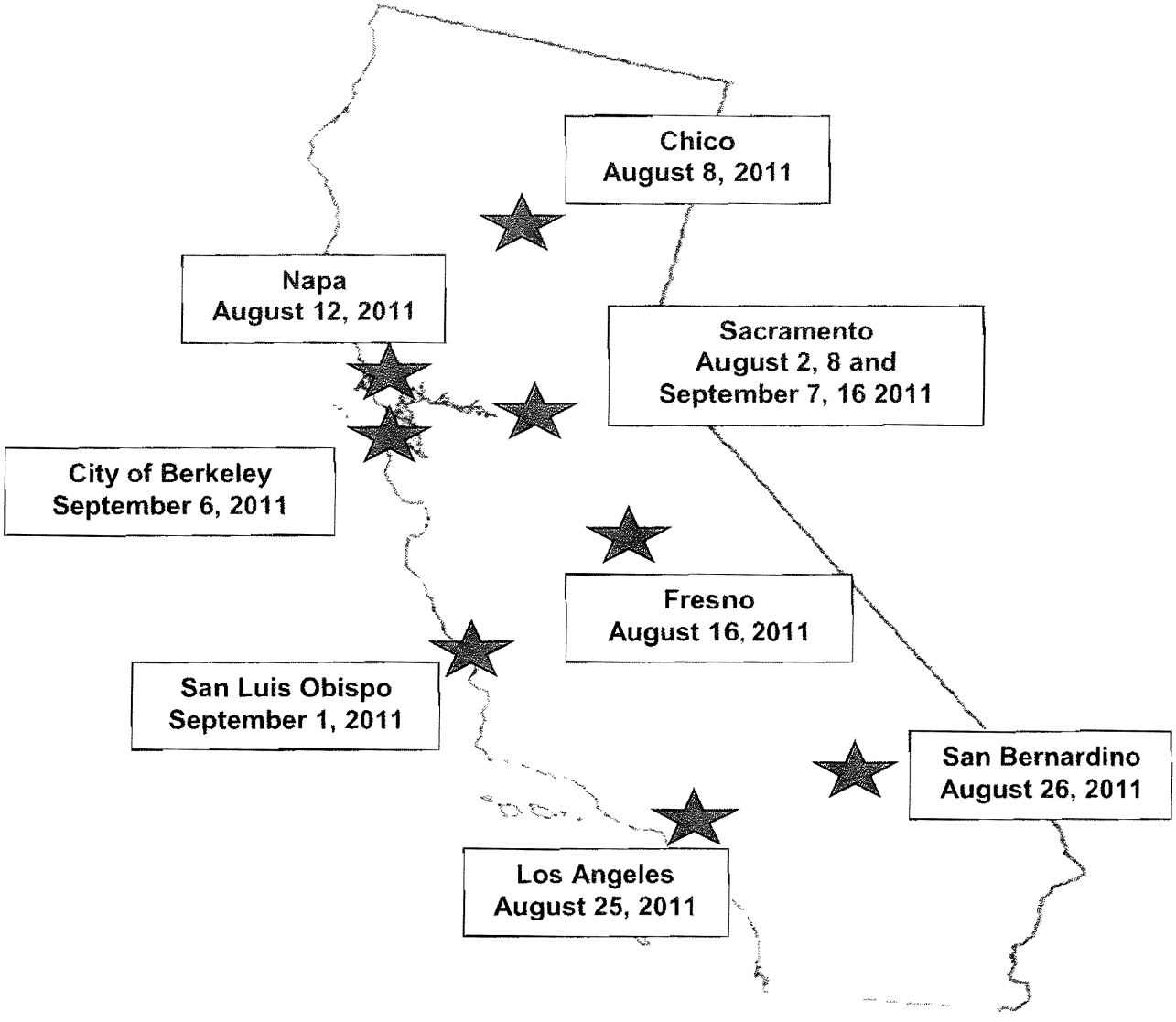
Meeting announcements were widely disseminated via DMH's vast distribution list, which includes a total of 323 individuals and organizations. Meeting participants were added to the distribution list using information provided on the sign-in sheets. DMH also encouraged partner organizations to invite local participants through their membership, contacts, and distribution lists. For each regional meeting, the Department worked with local partners including county and city Mental Health/Behavioral Health Department Directors and Cultural Competence / Ethnic Services Managers, private provider organizations, local mental health boards and commissions, as well as state level and local consumer organizations to:

- Schedule meetings at times that would result in high stakeholder turnout for meetings in their community;
- Seek referrals for interpreter services in threshold languages;
- Secure accessible, centrally located meeting facilities with telephone lines for remote participation; and
- Distribute meeting announcements and information to prepare for the stakeholder meetings.

Meeting Locations

Meetings were held in various locations throughout the state to ensure the greatest participation and diverse stakeholder input. The meeting approach included statewide meetings to be held in Sacramento and regional meetings. Locations for the regional (Northern, Southern and Coastal) meetings were carefully selected to ensure participation of large counties and their local stakeholders and small counties and their local stakeholders. A second Northern region meeting was added to the schedule to address the unique needs of the Greater Bay Area. Figure 1 on the next page highlights the locations of the stakeholder meetings.

Figure 1 Stakeholder Meeting Locations



In preparation for the regional stakeholder meetings, DMH hosted a Kick-off Stakeholder meeting in Sacramento on August 2, 2011. The purpose of the Kick-Off meeting was to present the proposed Community Mental Health Stakeholder process and meeting approach and to solicit feedback from participants. Stakeholders present at the meeting had considerable feedback about the meeting design, break-outs, stakeholder questions, and process. As a result, DMH refined the meeting approach for the regional stakeholder meetings.

In addition to the regional meetings held throughout the state, DMH arranged for two special sessions to present information about the Community Mental Health Stakeholder process and preliminary themes and findings. DMH sought focused input from both consumers and family members and county mental health directors, stakeholder groups of vital importance to California's public mental health system.

To that end, DMH partnered with DHCS to present the stakeholder process and to hear from participants at the 2011 NAMI California Conference on August 18, 2011. Representatives from NAMI CA were present at all of the regional stakeholder meetings; however, DMH's (and DHCS's) participation at the conference provided a unique opportunity for consumers and family members to voice their concerns and provide feedback regarding the future of mental health functions at the state level. NAMI California's formal recommendations are included in this report as Appendix XIV.

On September 7, 2011, DMH leadership met with the California Mental Health Directors Association (CMHDA) to obtain input from the CMHDA Governing Board. Representatives from the Mental Health Services Oversight and Accountability Commission (MHSOAC) and the California Mental Health Planning Council (CMHPC) were also invited to attend. As with all of the stakeholder meetings, this meeting was open to the public and a handful of consumers, family members, and advocacy organizations were present as well. CMHDA provided considerable input during this meeting. CMHDA's written recommendations about state mental health functions were developed and approved by all of California's county mental health directors. Formal recommendations from these organizations are included in Appendices X-XII. Input from these organizations is also reflected in the findings section.

Meeting Approach

Each regional meeting featured the following format:

Pre-Meeting Education Session – Each regional stakeholder meeting was immediately preceded by an education session designed to prepare attendees to participate in the stakeholder process. During the education sessions, DMH representatives provided background information about the legislative changes and state level mental health functions and responded to participant questions about the changes. In addition, participants were introduced to the stakeholder process and design, guiding principles, and the format and stakeholder questions for the stakeholder meeting that would follow. In addition, participants received information about how to contact the Department and where to direct additional feedback and questions about the process. Select meeting materials can be found in Appendix I of this report.

Community Mental Health Stakeholder Meetings – During the stakeholder meetings, a local mental health director and a representative from the DMH directorate welcomed participants. The agenda for the Stakeholder Meeting was similar to the Education Session agenda, with the addition of stakeholder reflections and small group breakout sessions. Breakouts were generally divided into three groups – Consumers/Family Members/Advocates, Providers, and County Representatives. At a handful of regional meetings, stakeholder groups were combined to balance out the small groups.

During the Stakeholder Meetings, participants were asked four sets of questions:

1. Based on today's presentation, what are the changes in mental health at the state level that stand out for you? (Large group)

2. Based on what you heard today, what opportunities do you see as a result of the transition at the state level? (Small groups)

3. Which entity should assume responsibility for the functions/programs listed?* What functions/programs are missing from the list? (Small groups)

   *For this question, facilitators walked participants through a handout that lists state mental health functions and state and local organizations. This handout can be found in Appendix I of this report.

4. What do you believe are the challenges associated with the changes to mental health at the state level? How can these challenges be addressed? (Large group)

Participant responses to all of these questions were captured on flipcharts by a recorder. At the conclusion of the small group breakouts, each group was asked to share with the large group the opportunities they identified (question #2).

Additional Vehicles for Stakeholder Input

DMH provided a variety of vehicles through which stakeholders could provide input including a Facebook page dedicated to the Community Mental Health Stakeholder Process. The Facebook page allowed stakeholders to provide feedback about the meetings as well as engage in interactive discussions with DMH staff via the discussion board option. DMH also utilized Twitter to keep "followers" apprised of upcoming stakeholder events. Furthermore, all meeting materials, including meeting announcements, PowerPoint presentations, and handouts were posted on the DMH website. Appendix XV includes screen shots of the DMH Facebook page, Twitter page, and DMH website.

Stakeholders were encouraged to provide input electronically and in person by:

- Sending additional comments and recommendations to DMH at CommunityMHStakeholder@dmh.ca.gov;
- Visiting the CA Community Mental Health Stakeholder Page on Facebook;
- Following CAMHStakeholder on Twitter; and
- Submitting comment cards to DMH representatives at a stakeholder meeting.

Comments received through these vehicles were reviewed and analyzed along with all other input gathered during the stakeholder process.

Constraints and Challenges

While the Community Mental Health Stakeholder process resulted in enthusiastic and diverse stakeholder participation, the process was limited by the following constraints:

Compressed timeline – One of the Department's goals for this process is to ensure that a summary of stakeholder input (i.e., this report) is provided to the public in time for the Governor's budget consideration later this year. This goal required that organizing, scheduling, design, planning, marketing, outreach, education, and convening of these regional meetings occur in a very compressed timeframe. As a consequence, announcements for some of the regional meetings were not disseminated in the desired lead time to achieve maximum stakeholder outreach and subsequent participation.

Qualitative results – DMH designed these stakeholder meetings as focused conversations to gather opinions, input, and recommendations. It is not possible to report the number of stakeholders that share a specific concern, opinion, or recommendation. Rather, the feedback is conveyed through narrative themes that emerged from the stakeholder meetings.

Stakeholders' limited knowledge of and familiarity with state mental health programs and functions – State mental health functions are myriad and complex. Many stakeholders at each regional meeting indicated that they do not have sufficient knowledge to make informed recommendations about state level functions. During the meetings, DMH representatives educated stakeholders about the functions; however, an in-depth education strategy was not an option due to time constraints.

Resources – The State and local mental health departments are undergoing tremendous organizational and system change and budgetary challenges. Devoting limited staff resources and time to these meetings required a tremendous amount of planning and dedication by the public sector.

Translation and Interpretation Services – The State DMH and local mental health departments demonstrated their commitment to ensuring language access by investing resources for translation of meeting announcements and interpreter services for all of the Community Mental Health Stakeholder Meetings. The availability of interpreters allowed for the participation of Limited English Proficient (LEP) and monolingual stakeholders from California's ethnically and linguistically diverse population. With the assistance of the county mental health departments' Ethnic Services Managers, DMH was able to provide interpreter services at each of the regional meetings in the county's threshold language as well as American Sign Language (Los Angeles and San Bernardino).

Stakeholder Process Outcomes

Throughout the Stakeholder Summer 2011, the State DMH conducted a total of twelve stakeholder events, including eight regional stakeholder meetings across the state over a six-week period, August 2, 2011 to September 7, 2011.

Stakeholder Meeting Participants by Location

Stakeholder meeting participants were asked to sign-in and identify themselves in one of four stakeholder groups: 1) Consumer/family member/advocate; 2) Provider; 3) County Representative; and, 4) Other[1]. Table 2 below shows the number of participants by stakeholder group at each meeting (based upon information provided on sign-in sheets).

Table 2 Community Mental Health Stakeholder Meeting Participation

Location and Date	Consumers/ Family Members/ Advocates	Providers	County Employees	Other	Phone Participants	Total
Sacramento Kick-off August 2, 2011	17	17	10	34	181	259
Butte County August 8, 2011	10	20	16	7	24	77
Napa County August 12, 2011	4	7	7	1	12	31
Fresno County August 16, 2011	40	12	11	17	31	111
NAMI CA Conference, Sacramento, August 18, 2011	85	9	3	1	N/A	98
Los Angeles County August 25, 2011	115	93	33	6	13	260
San Bernardino County August 26, 2011	31	30	30	0	1	92
San Luis Obispo County September 1, 2011	9	24	32	2	5	72
City of Berkeley September 6, 2011	2	5	8	5	3	23
CMHDA September 7, 2011	3	0	18	3	3	37
Total	316	217	168	76	273	1060

[1] The "Other" category includes legislative staff, college/university staff and/or students, and individuals who did not identify themselves.

Findings

The section that follows describes the findings from the stakeholder process. The input gathered during the process was compiled, analyzed, and organized into themes. The themes are supported by direct quotes from stakeholder comment cards or emails and/or flipchart notes from one or more of the Community Mental Health Stakeholder Meetings. The selected quotes are representative of stakeholder input. Many additional comments related to the themes were submitted to DMH. Notes from each meeting, including stakeholder comments captured on flipcharts, can be found in Appendices II- IX of this report.

The input gathered at the meetings was as varied as the consumers, family members, advocates, county representatives, and providers who participated in the process. The themes presented below are perspectives that were heard consistently. In some cases the themes contradict each other – a reflection of the diverse and divergent voices of individuals with an interest in the mental health system. Notably, no consistent themes emerged across like groups. For instance, while some consumers/family members advocated for local control; other consumers/family members expressed anxiety that counties would not be held accountable for providing quality services.

In general, stakeholders did not reach consensus about which entity should be responsible for state level mental health functions. While many stakeholders believed that some of the functions should remain at the state level, references to "the State" in stakeholder comments typically do not denote a preference for a particular state organization, including the Department of Mental Health.

The themes are organized into five overarching themes:

1. Concerns Regarding State Level Mental Health
2. Benefits and Challenges of Local Control
3. Importance of Cultural Competence Leadership and Reducing Disparities
4. Integrity of the Mental Health Services (MHSA) Act
5. Role of Mental Health Consumers and Their Families

1. Concerns Regarding State Level Mental Health

While it is difficult to quantify stakeholder perception regarding the placement of state level mental health functions, clear themes about priorities emerged during the stakeholder meetings. Themes associated with placement of mental health functions are described below.

According to community mental health stakeholders, state level executive leadership for community mental health is essential.

> *"Where is the executive leadership in the current DMH organization chart?"*
>
> *"The mental health leadership needs to have subject matter expertise."*
>
> *"Administrative leadership needs dedicated positions with individuals with content expertise in decision-making. Mental Health executive role decision-makers should remain, so there is structure, stability, and mental health administration."*

For many stakeholders, oversight (e.g., plan review, auditing, ensuring county compliance, etc.) is the most important state mental health function. While there was no consensus across stakeholder groups about which state entity should be responsible for oversight, stakeholders believe that there is a clear role for the state in ensuring that counties are held accountable for MHSA provisions.

> *"The State needs to provide a leadership and oversight role. There should be some strong commitment to leadership and oversight and standardization. Some counties do not roll out services in a consistent manner."*
>
> *"There is a need to expand oversight and have an entity to assume this function."*
>
> *" [I am] concerned about quality of services with no state level oversight. Our county is the gold standard, but what about other counties that don't have enough staff?"*
>
> *"If the money goes to the locals, who is going to have oversight of the counties (besides the Board of Supervisors)?"*
>
> *"The MHSA was supposed to be transformative, voluntary services. With a lack of state level oversight, who will ensure that services will be voluntary?"*

Effective financial oversight is also a high priority for mental health stakeholders. However, there was no consensus as to who should be responsible for this function.

> *"We need local authority for financial oversight. However, there is a risk of abuse if there is a lack of oversight."*
>
> *"The state should retain responsibility of financial oversight."*
>
> *"CalMHSA should have financial oversight."*

While stakeholders believe that program evaluation and quality improvement are essential functions, there was no consensus regarding where those functions belong (state vs. local level).

> *"When it comes to data and quality improvement, it can be difficult to do that locally because we are too close to the action or we don't see the flaws or cover-ups."*
>
> *"It should be a collaborative process that includes state and local systems."*
>
> *"We want support from the state but we also want local control of quality improvement and program evaluation."*
>
> *"The state can provide education and technical assistance."*

Time and again, stakeholders expressed their hope that this change will give mental health equal "footing" with physical health and position the state for national healthcare reform.

> *"The most exiting opportunity is the potential for mental health services to be integrated with public health approaches and practices."*
>
> *"Organizing around funding source fragments and creates silos. We need to think 5-10-15 years. Healthcare reform. I would like to see a Department. of Health Systems w/ DHCS, ADP, DMH "not merging" but coming together as systems."*
>
> *"...Given the major shifts in our nation's health care policies, we believe an integrated focus on mental health, substance abuse, and physical health is more feasible if the various government healthcare programs are administered by one state entity."*

While many stakeholders see advantages to integrating mental health and alcohol and other drugs, they are fearful that mental health and substance use disorders will become the "step children" in the public health system.

> *"Within community health clinics, there is a concern about physical healthcare trumping everything. Is there a way to stage it so that specialty mental health services don't get lost?"*

"The integration of mental health, substance abuse, and physical health presents the danger of loss of identity as well as financial dependence for mental health which may eventually hurt the mental health budget because, historically, physical health always gets the priority. We need to be extremely vigilant to avoid that kind of uncertain future for mental health."

"Putting Mental Health and substance abuse under DHCS is ok if: 1) they combine mental health and substance abuse and create a HIGH LEVEL leader and function within Health Care Services. 2) Initial funding for both services is same (or higher) and it increase over time, commensurate with need."

"I agree with the danger of fragmentation. We need unifying principles. If DMH and ADP are folded into DHCS, they should change their name to be more inclusive and unifying."

Some stakeholders expressed support for a single state organization responsible for behavioral health.

"To maintain "statewideness" there should be a single Behavioral Health entity."

"Maintain or make a separate bureau/dept. for Behavioral Health to preserve the voice of Mental Health and to assure direct communication with the Director of DHCS."

Many see the integration of mental health and alcohol and drug programs as essential to preventing consumers with co-occurring disorders from "slipping through the cracks."

"When Alcohol and Drug and mental health are joined, there are greater co-occurring services at local level. If the state combines, the state might be better coordinated between both sides, make it easier to treat both at same time."

"[Create] new programs addressing dual problems where resources can be used across both conditions."

"I feel that 70% of consumers have alcohol and drug issues, then they should be connected more (co-occurring disorders). "

"This is a good opportunity to meld co-occurring disorders together, keep things from slipping through the cracks."

"Having DHCS administer both mental health and substance use programs will provide an integrated focus on mental health, substance use, and physical health. Given the broad overlap among populations of individuals in need of mental health care, substance abuse disorder treatment, and primary health care, we think it makes sense that the variety of government programs in these arenas be administered by one state agency."

Stakeholders want to ensure that mental health expertise is not lost with the shifting of mental health functions away from DMH.

"If we shift functions to different departments, there won't be sufficient training for new departments [so they] can do the work."

"With Medi-Cal mental health functions transferring to DHCS, will there be staff with the mental health background and knowledge to perform these functions?"

"We need to educate DHCS on mental health and substance abuse wellness and recovery principles so they become true equal partners as we head towards health care reform. "

Many stakeholders were dismayed by the current number of DMH staff and expressed concern that the Department has "an impossible job" with the current number of resources.

"There are a tremendous number of functions now at DMH – I'm concerned something will fall through the cracks."

"It's not possible to answer the question of what to do with 19 staff and where to put the remaining functions. It's an impossible situation."

Many stakeholders advocated for keeping the Department of Mental Health in tact.

"...we want to protect the identity of the California Department of Mental Health. Don't disperse the functions that remain."

"Reorganizing CA Healthcare Department, how much money does CA State save? I think keeping DMH as it is now is much better because DMH has good insight about Mental Health and substance abuse. Transforming Medi-cal of DMH and Substance Abuse to [DHCS] might damage the good services [provided] to needy people."

"Giving functions to DHCS is risky. The Department. of Mental Health has acknowledged and supported the Recovery Model described in the Mental Health Service Act. Advocacy groups were encouraged and heard. Without a department at the state level, I am very concerned that the process of transforming mental health services to ones that are truly client-driven and family-focused will be lost."

2. Benefits and Challenges of Local Control

Stakeholders embraced the potential benefits of local control including a larger role for local Mental Health Boards and Commissions and more responsive planning.

"...Because of the composition of all the county mental health boards and commissions, statewide, our respective commissions offer another avenue to involve consumers in this process and to provide a voice to concerned members of the public. I hope our government is receptive to listening to the concerns and recommendations of mental health consumers and advocates. "

"More local control with focus – hopefully with local Mental Health Boards and Commissions."

"This can create a more organic process – an opportunity to really hear from county boards."

"Hopefully this will result in bottom-up planning that is more responsive. Counties are the experts."

"Tighter link between community needs and county response may lead to more customized/ pilot programs/creative intervention programs/innovative programs."

"Helps for services to be at the county level because we are closer to the people receiving services. We know our demographic and can tailor services."

Stakeholders also hope that current realignment efforts will alleviate bureaucracy.

"To facilitate improvement of mental health services, make documentation/paperwork more uniform, easier to understand, a 'boilerplate' to provide services. Design a standardized process from county to county."

"Streamline extra bureaucratic layers that use up funds."

"Reduce paperwork/eliminate duplication, pay providers quicker."

"Reducing counties' required administrative activities would help counties maximize available resources to provide direct consumer services."

In addition, stakeholders are hopeful that reporting requirements and audit activities can be streamlined and centralized.

"We should have one centralized location to report data so counties do less work and spend less time on reporting."

"Reduce the duplicated requirements due to different funding streams with different funding requirements."

"Bringing enforcement/documentation in-house is a good opportunity. We are spending time trying to anticipate auditors (gathering documentation, treatment plans). It would be wiser to spend time seeing clients and not worry about documentation standards."

"Unless the CSI [Client Services Information] system will change, it makes sense to have counties report this data to one entity with a unified data set and one way of reporting."

Stakeholders expressed a desire for improved data access.

"Wherever this information lives (data) there has to be a uniform/shared system so that everyone (all State entities) can have access to this information merged reporting system."

"It is important to create opportunities for counties to extract and utilize data."

"Make data more accessible. ADP does a great breakdown for every county. They do the work for me."

Stakeholders see changes at the state level as an opportunity for new rules that remove barriers to services.

"Current rules and regulations surrounding MHSA funds are too strict and prohibitive. Many people are not able to access all the services they need because of these rules. This is an opportunity to remove many of these barriers and be able to provide services that are tailored to certain populations."

"Currently, there is a disparity between the way in which Medi-Cal services and community mental health services are provided and funded. This is an opportunity to balance out this disparity."

At the same time, stakeholders expressed concern that local control comes with risks and challenges including local inexperience with MHSA:

"It makes sense to realign to the local level only if locals know what they are doing - rural counties do not have as much history with MHSA; knowledgeable staff is retiring/leaving; there is a reluctance to hire consumers."

"There are unique challenges for small counties."

"There is an assumption that counties have the expertise that is 95% true, but that is not necessarily true about housing. It's a whole different field, level of expertise, etc. County mental health/behavioral health providers are not housing experts. Serious thought needs to be given to this if these responsibilities are shifted to the local level."

The most commonly voiced concern associated with local control related to local accountability.

"[We need] protections so that counties don't redirect funds if they don't think mental health is important."

"Local control is disempowering for people. Where is the accountability? We need to create an enforcement system."

"It is critical for the state is to provide accountability for program evaluation – there must be documentation that programs are getting the outcomes that are significant."

"While program administration and delivery of services are the responsibility of counties, it remains the responsibility of the state to ensure the counties administer the programs and delivery of services in accordance with applicable state and federal law."

Many stakeholders expressed apprehension that a shift to local control will result in inequities.

> *"Shifting responsibilities is both an opportunity and risk – local fairness is an issue."*

> *"What about small cities (or counties)? Will there be a difference between those that have more resources and those that have less resources? How do we balance that issue? My nephew had to come to a larger county to get more services. Counties need sufficient resources for our families and consumers."*

Some stakeholders expressed concern that more local control result in decreased "statewideness."

> *"How can we measure the impact of programs and services on a statewide basis? How will we be able to share best practices statewide?"*

> *"We could put federal funding at risk if we don't have a statewide standard measurement system. There has to be consistency of care."*

3. Importance of Cultural Competence Leadership and Reducing Disparities

Stakeholders see a continued focus on cultural competence and reducing disparities as a high priority and an essential element of the mental health system.

> *"...Must prioritize prevention efforts in addressing disparities...On a local level they can create cultural centers as one stop meeting points and wellness centers incorporating non-traditional partners. Disparities affecting African Americans are appalling throughout the state."*

> *"We need to support Asian American/Pacific Islanders consumer/peers as advocates and community mental health workers by funding culturally competent training, advocacy and wellness peer programs that are facilitated by API peers because of stigma culture, we lack API peer services."*

> *"I would like to request that the Office of Multicultural Services remain in tact. We need this office to make sure we have programs like Native American Health Center that can provide specialized care for a population that is underserved and not served appropriately by the county."*

"[The state should] demonstrate commitment to ethnic diversity and cultural inclusion of older adults, deaf and hard of hearing and legally blind."

"If the Office of Multicultural Services is not preserved, the quality of California's commitment to culturally competent mental health services and reducing mental health disparities would be in jeopardy. That office is in charge of many important projects including the California Reducing Disparities Project and oversight of the Cultural Competence Plan Requirements report."

Stakeholders want to state leadership for cultural competence at the highest levels.

"There should be continued focus on the office of multicultural services given the vast disparities in underserved and under represented communities. To guarantee this focus, the Office of Multicultural services should be high up in any organizational chart."

"It is vital that the Office of Multicultural Services (OMS) remain in tact, including retaining the Chief's position that reports directly to a department or agency director. Cultural competence and reducing disparities need to be given the high priority that is required to achieve the progress in mental health services in California."

"...Adequate, high-level leadership within DHCS would be charged with promoting mental health, wellness, resiliency and recovery in California's diverse communities."

4. Integrity of MHSA

Stakeholders recognize the tremendous progress that has resulted from the MHSA, and, overwhelmingly, do not want to "go backward" as a result of realignment.

"Fear of "step back" to medical model instead of recovery model."

"[We need to] maintain institutional memory of how things happen (i.e., DMH and system in general), this is not the first time that there has been major change. What will happen to people in poor communities? There is some ongoing memory of what is happening right now, some continuity of history."

"Changes are great and often necessary however fragmenting our services will not improve the quality services instead it might create more chaos and separation. Instead, if we have to "transfer" services to Public Health for instance, why not join them, or have them join our services and review together what we had done, so far, what had not worked and how to move forward in a partnership fashion. MHSA has been the best thing that has happened in the last few years. Why reinvent something that is working well?"

"Keeping alive the core of the things we learned through MHSA will help us through this transition."

Stakeholders indicated that any changes in the mental health system must continue to reflect the MHSA general standards:

Continue to focus on wellness, recovery, and resilience.

"Expand the concept of wellness and recovery across the system of care. Wellness and recovery can become the baseline for all services."

"Client/Recovery movement cannot lose its momentum. Wellness and recovery's higher standard should be the minimum, raise the standards across the board."

Continue to strive toward an integrated service experience for consumers and family members, avoid fragmentation at all costs.

"Fragmentation of responsibilities leaves the consumer with more difficulties in navigating the system of care but will also increase cost."

"We do not support the fragmentation of authority which would likely cause difficulty for providers in accessing funding, which could disrupt services. If system changes must take place, individuals with expertise in mental health should be in place at other departments now in charge and DMH should remain as a pass-through or as a guidance resource for these other department."

"The transfer of the Medi-Cal functions for mental health makes good sense and will increase efficiency. However, to further fragment the mental health functions that were delivered by State DMH between the MHSOAC and other agencies is a mistake. There must be a strong centralized organization for all other mental health functions but MOST of ALL there must be LEADERSHIP in Sacramento related to development."

"It is better to have one system of care. Having the functions/funding broken up could cause more problems (e.g. reporting to multiple entities)."

"The mere co-location of DMH subsumed within DHCS does not guarantee true integration of care."

Stakeholders want to ensure that the focus on prevention and early intervention is not lost as a result of the state mental health changes.

"Prevention and Early Intervention funding is a state level funding source – we should not lose PEI focus."

"While it is important for counties to have local control on how services are prioritized and delivered, it is equally important to have statewideness in mental health policy. Mental health policy in California has not been proactive in the past but, with the advent of parity and health care reform, there is an opportunity for development of mental health policy that includes more prevention and early intervention. It is clear that good mental health services/treatment initially can prevent expensive hospitalization and incarceration and great human costs. Development of prevention and early intervention services statewide makes good economic sense and would be good public policy."

5. Role of Mental Health Consumers and their Families

Mental health stakeholders are concerned that their voices will be lost in the realigned mental health system.

"Who will speak for community in the new reality?"

"I think there needs to be a louder consumer/voice in this whole DMH → DHCS transition process and would be willing to work on that level. I am from a smaller county (Butte) and am very concerned that the "little person" is being over looked."

"As a youth with a family with mental health, how can I, or other youth become more involved and aware of what's being changed, how can we have a say and have our voice inputted when there isn't a voice for us (or representation). Are their trainings or workshops out there for the youth?"

"This is an excellent opportunity to include "meaningful" recommendations from all of California's citizens. The greatest challenge is to not maintain the "status quo." Simply because the belief is that there is no money to meet the MHSA expectations as governed by the law and what the citizens of the Great State of California express what they need in order to experience good mental health."

"How do we keep the consumer voice at the state level?"

"Will state legislators still listen to local stakeholder input without support of state DMH?"

"[I am] concerned, in this transition, that we might lose a statewide voice and advocacy in Administration. Maintain a strong statewide voice in light of healthcare reform to work with the Feds to keep mental health in the discussion and prevent our folks from becoming more invisible."

"WE MUST BE AT THE FINAL DECISION MEETINGS –Nothing About Us Without US. That Means ALL of us."

At the same time, stakeholders see the changes as an opportunity for new voices to be heard. The changes at the state level provide opportunities for:

"...others to come to the table to provide input."

"...youth engagement."

"...more partnerships with Aging groups and regional centers."

Summary

The findings from the Community Mental Health Stakeholder Process reflect the diversity of California. While some stakeholders are ready to embrace the impending changes; others are anxious and uncertain about what these changes will bring. It is clear; however, that California's mental health stakeholders were appreciative of the opportunity to provide input into the current realignment efforts and transition of functions. Stakeholders are also eager to continue their participation in the process and want to stay informed of all decisions made about the future of mental health at the state level.

The five overarching themes described in this report reflect the areas of most concern to the stakeholders. At each regional meeting, the stakeholders expressed their ideas about oversight, local control, cultural competence, the role of mental health at the state level and the need for continued mental health leadership, and, most commonly, the continued role of consumers, family members, and community members in the decision-making process. While many stakeholders found it challenging to provide specific recommendations about the placement of mental health functions, most stakeholders expressed the need for inclusion, efficiency, streamlined data reporting processes, mental health leadership, improved access to and navigation of comprehensive services, and the ability to plan for the future with health care reform in anticipation of an integrated service system.

The DMH Community Stakeholder Process was successful despite the constraints and challenges (compressed timeframe, lack of qualitative results, etc.), because the stakeholders are deeply and personally invested in ensuring the continued funding/resource allocation, parity, accessibility, and quality of services in California's public mental health system.

Next Steps

This report will be released for public review on September 16, 2011 following a statewide webinar to review the findings from the Community Mental Health Stakeholder Summer. DMH intends to host subsequent webinars on September 23, 2011 and September 30, 2011 to allow for stakeholder response to the report. All stakeholder comments on the draft report will be considered for inclusion in the final report, to be released in mid-October (2011). Stakeholders may provide feedback to the report via the webinars, email, and/or the Facebook discussion boards. The final report may be used for consideration regarding the Governor's policy, program, and budget decisions for 2012/2013. DMH's commitment to engage stakeholders will continue through monthly meetings during October 2011-June 2012. These monthly meetings will afford stakeholders the opportunity to provide on-going feedback as the state level transition unfolds. DMH will also continue to post new information, as it becomes available, on the DMH website; as well as monitor and post on Facebook and Twitter. Stakeholders are encouraged to continue participation in this ongoing Community Mental Health Stakeholder Process.

Stakeholders may continue to provide input through the following vehicles:

DMH Website

Please visit the Medi-Cal Transfer, Stakeholder Summer 2011 and Realignment Information webpage:

www.dmh.ca.gov

Click on **"Information Regarding the DHCS/DMH Medi-Cal Transfer, Summer Stakeholder, and Realignment"** under the "What's New?" section for meeting notices, information, and updates.

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Twitter

Follow **CAMHStakeholder** on Twitter

Additional Comments?

Send written comments to:
CommunityMHStakeholder@dmh.ca.gov

**If you would like your comments to be posted on the DMH website, please indicate your permission in your email message.

Appendices

I Select Community Mental Health Stakeholder Meeting Handouts

II Notes from Sacramento Kick-Off Stakeholder Meeting August 2, 2011

III Notes from Butte Regional Meeting August 8, 2011

IV Notes from Napa Regional Meeting August 12, 2011

V Notes from Fresno Regional Meeting August 16, 2011

VI Notes from NAMI CA Conference Stakeholder Meeting August 18, 2011

VII Notes from Los Angeles Stakeholder Meeting August 25, 2011

VIII Notes from San Bernardino Stakeholder Meeting August 26, 2011

IX Notes from San Luis Obispo Stakeholder Meeting September 1, 2011

X Notes from City of Berkeley Stakeholder Meeting September 6, 2011

XI California Mental Health Directors Association Recommendations

XII Principles to Achieve Oversight and Accountability in a Changing Mental Health Services Environment- Mental Health Services Oversight and Accountability Commission

XIII National Alliance on Mental Illness, California Position Paper

XIV Rose King Comments on Community Services and Supports

XV DMH Website, Facebook and Twitter Pages

XVI DMH Acknowledgements

XVII List of Participating Organizations

Appendix I

Select Community Mental Health Stakeholder Meeting Handouts

- **Common Abbreviations and Acronyms for Stakeholder Meetings, Summer 2011**
- **Background Summary**
- **Sample Slide Deck From Regional Meetings**
- **Community Mental Health Functions Handout**

CALIFORNIA DEPARTMENT OF
Mental Health

Common Abbreviations and Acronyms for Stakeholder Meetings
Summer, 2011

The following is a brief list of terms that are likely to be used by the Department of Mental Health. While not complete, the list is designed as an initial glossary.

State Department of Mental Health Programs

EMHI	Early Mental Health Initiative
PATH	Projects for Assistance in Transition from Homelessness
SAMHSA	Substance Abuse and Mental Health Services Agency Block Grant

Stakeholder Groups

ADP	Alcohol and Drug Programs Department (State of California)
CiMH	California Institute of Mental Health
CMHDA	California Mental Health Directors Association
CMHPC	California Mental Health Planning Council
CNMHC	California Network of Mental Health Clients
DHCS	Department of Health Care Services (State of California)
DMH	Department of Mental Health (State of California)
NAMI	National Alliance on Mental Illness
OAC	Mental Health Services Oversight and Accountability Commission (aka MHSOAC)
REMHDCO	Racial and Ethnic Mental Health Disparities Coalition
UACF	United Advocates for Children and Families
MHAC	Mental Health America California

Governing Legislation

AB 100	Elimination of State approval of county MHSA programs
AB 102	Transfer of Medi-Cal specialty mental health services from DMH to DHCS
AB 106	Transfer of drug Medi-Cal programs from ADP to DHCS

Mental Health Services Act

MHSA	Mental Health Services Act
PEI	Prevention and Early Intervention
CSS	Community Services and Supports
FSP	Full Service Partnerships
INN	Innovation
WET	Workforce, Education and Training

CALIFORNIA DEPARTMENT OF
Mental Health

Department of Mental Health Stakeholder Education Summary

Proposition 63 – Mental Health Services Act (MHSA)

The passage of Proposition 63 (known as the Mental Health Services Act, or MHSA) in November 2004, provided the opportunity for the California Department of Mental Health (DMH) to increase funding, personnel, and other resources to support county mental health programs and monitor progress toward statewide goals for children, transition age youth, adults, older adults, and families. The MHSA imposes a 1% California state income tax on personal income in excess of $1 million. Much of the funding has been provided to county mental health programs to fund activities consistent with their local plans. An extensive stakeholder process was held in 2005 to share the State's implementation efforts.

Assembly Bill 100 (AB 100), Committee on Budget, Mental Health Services Act

The enactment of Assembly Bill (AB) 100 significantly changed the responsibilities of DMH in the administration of the MHSA. AB 100 amended the Welfare and Institutions Code and eliminated the requirement that DMH and the Mental Health Services Oversight and Accountability Commission review, comment on, and approve County Plans and annual updates. In keeping with the Governor's intent to place decision-making authority at the level closest to the people who benefit from the services, AB 100 presents an opportunity to streamline and improve policies and procedures to allow counties to more effectively implement MHSA funded programs. Therefore, the day-to-day activities and operations related to the implementation of the MHSA have been realigned to the counties.

New departmental structures to be discussed at the California Community Services Stakeholder Meetings, 2011-2012:

- Department of Health Care Services (DHCS), DMH, and Alcohol and Drug Programs (ADP) Medi-Cal transfer (AB 102 and AB 106)
    - AB 102, Committee on Budget, Health – California's Health Budget Trailer Bill for Fiscal Year 2011-12 (AB 102) directs the Department of Health Care Services (DHCS) and the Department of Mental Health (DMH) to create a State administrative and programmatic transition plan to guide the transfer of the Medi-Cal specialty mental health and EPSDT Program services to DHCS, effective July 1, 2012. The bill also requires the departments to convene a series of meetings and forums with stakeholders to include their input in the creation of the transition plan. It is the intent of the Legislature to consolidate state administrative functions for the operation of Medi-Cal specialty mental health services and to transition those functions to the State Department of Health Care Services in order to (a) improve access to mental health services, including a focus on recovery and rehabilitation services, (b) more effectively integrate the financing of services, (c) improve state accountabilities and outcomes, and (d) provide focused, high-level leadership for behavioral health services.

- AB 106, Committee on Budget, Human Services - California's Health Budget Trailer Bill for Fiscal Year 2011-12 (AB 106) directs DHCS and ADP to create a State administrative and programmatic transition plan to guide the transfer of the Drug Medi-Cal Program to DHCS, effective July 1, 2012. AB 106 requires DHCS to submit a transition plan to the California Legislature by October 1, 2011.

Community mental health policy, program and implementation

- DMH is convening a series of community mental health stakeholder meetings throughout the State to inform people about changes to state-level mental health administration and listen to ideas, input, and concerns regarding the DMH non-Medi-Cal activities and programs. This input will be summarized in a report to the Legislature, due February 1, 2012.

DMH Community Services Division 2011-2012

- Transfer Medi-Cal functions to DHCS by July 1, 2012
- Office of Mental Health Services Act (OMHSA)- 19 Total Positions
  - Housing
  - Suicide Prevention
  - Stigma Mitigation
  - Data Collection and Reporting
  - Contract Administration
    - California National Alliance on Mental Illness (NAMI)
    - California Network of Mental Health Clients
    - Office of Multicultural Services
    - United Advocates for Children and Families
    - California Institute for Mental Health
  - Federal and State Grant Administration
    - Substance Abuse and Mental Health Services Administration (SAMHSA) Community Development Block Grant
    - Project for Assistance in Transition from Homelessness (PATH)
    - Early Mental Health Initiative (EMHI)

DMH Community Mental Health Stakeholder Regional Meeting

California Department of Mental Health

Acknowledgements

- DMH would like to thank our partners:
  - California Health and Human Services Agency (CHHS)
  - Mental Health Services Oversight and Accountability Commission (MHSOAC)
  - California Mental Health Directors Association (CMHDA)
  - California Mental Health Planning Council (CMHPC)
  - CA Department of Alcohol and Drug Programs (ADP)
  - CA Department of Health Care Services (DHCS)
  - CA Network of Mental Health Clients (CNMHC)
  - National Alliance on Mental Illness, California (NAMI CA)
  - United Advocates for Children and Families (UACF)
  - Racial & Ethnic Mental Health Disparities Coalition (REMHDCO)
  - CA Association of Local Mental Health Boards (CALMHB)
  - California Institute for Mental Health (CIMH)
  - Workforce Education & Training Regional Partnerships
  - Local Partners (e.g. Mental Health Service Providers, Consumers, Family Members, etc.)

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Social Media Updates

- **Facebook**
  - Visit the **CA Community Mental Health Stakeholder** page on Facebook
  - http://www.facebook.com/pages/CA-Community-Mental-Health-Stakeholder/179811872085830
- **Twitter**
  - Follow **CAMHStakeholder** on Twitter

3

Facilitator for Today's Meeting

Eileen Jacobowitz
EJC Consulting

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Overview of Today's Meeting

- Welcome and Introductions
- Meeting Overview and Goals
- Background and Context
- Stakeholder Reflections
- Small Group Break-Outs
- Small Group Summary
- Large Group Question
- Next Steps

5

Language Access

- DMH recognizes the importance of language access for Limited English Proficient (LEP) and monolingual stakeholders. In an effort to improve communication and interaction with LEP and monolingual individuals, DMH is committed to:
  - Translation Services
  - Interpreter Services

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Goals of the Community Mental Health Stakeholder Meetings

- Create fully-inclusive stakeholder participation process
- Communicate clearly about current state DMH re-organization
- Educate stakeholders about the role, responsibilities and resources for the DMH
- Support efficiency and effectiveness for the community mental health system
- Develop a summary report in time for Governor's Budget consideration

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Purpose of the Community Mental Health Stakeholder Meetings

- Gather stakeholder input on future functions and program responsibilities
- Determine appropriate organizational placement of functions
- Define Community Mental Health roles/responsibilities

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Elements of the Process

- Planning & Design in Collaboration with: ADP, DHCS, MHSOAC, CMHPC, DMH OMS, CNMHC, NAMI CA, CALMHBC, UACF, CMHDA, CIMH, WET Regional Partnerships
- Pre-Meeting Education Prior to All Meetings
- Regional Meetings Throughout the State
- Statewide Webinar to Review Summary of Stakeholder Input
- Monthly Stakeholder Meetings from October 2011-July 2012

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Community Mental Health Stakeholder Meeting Schedule Stakeholder Summer 2011

Date	Activity
Tuesday August 2, 2011	Kick-Off Stakeholder Meeting Sacramento
Monday August 8, 2011	Regional Stakeholder Meeting Chico
Friday August 12 2011	Regional Stakeholder Meeting Napa
Tuesday August 16, 2011	Regional Stakeholder Meeting Fresno
Thursday August 18, 2011	NAMI Conference Sacramento
Thursday August 25, 2011	Regional Stakeholder Meeting Los Angeles
Friday August 26, 2011	Regional Stakeholder Meeting Ontario
Thursday September 1, 2011	Regional Stakeholder Meeting San Luis Obispo
Tuesday September 6, 2011	Regional Stakeholder Meeting Bay Area
Wednesday September 7, 2011	CHHS/DMH/DHCS/ADP Stakeholder and Interest Groups Check-in Sacramento
Friday September 16 2011	Statewide Webinar to share stakeholder input from all sessions Sacramento
October 2011- July 2012	DMH will sponsor monthly stakeholder community services education and update meetings

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Background and Context

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Legislative Changes

- **Review of Background Summary Handout**
  - **Assembly Bill 100 (AB 100),** Committee on Budget, Mental Health Services Act
  - Department of Health Care Services (DHCS), DMH, and Alcohol and Drug Programs (ADP) Medi-Cal transfer
    - **AB 102**, Committee on Budget, Health
    - **AB 106**, Committee on Budget, Human Services

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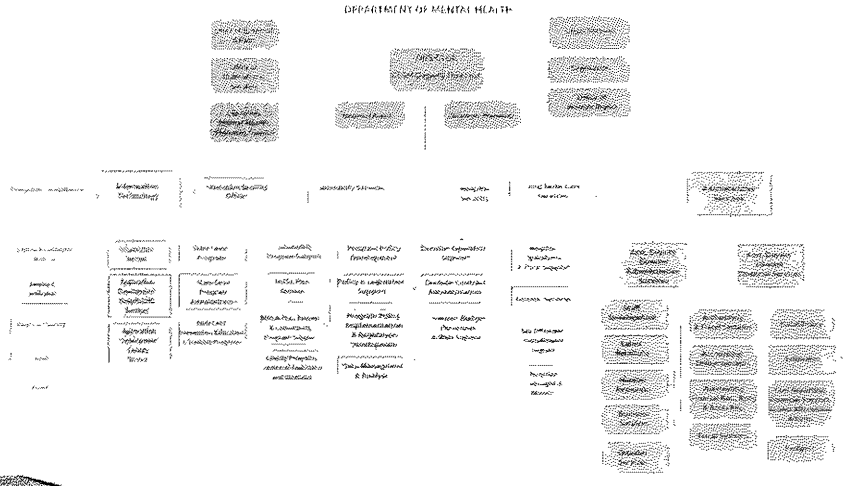
Department of Mental Health Prior to AB100



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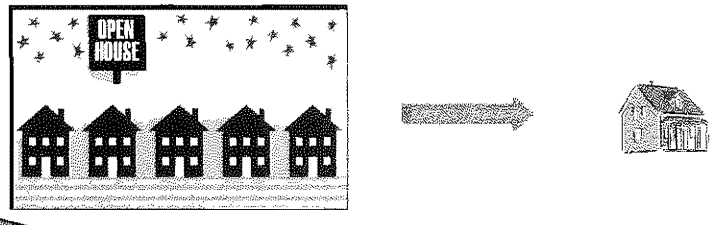
What Does DMH Look Like Today?

Community Mental Health

Number of staff reduced from 114 to 19 positions



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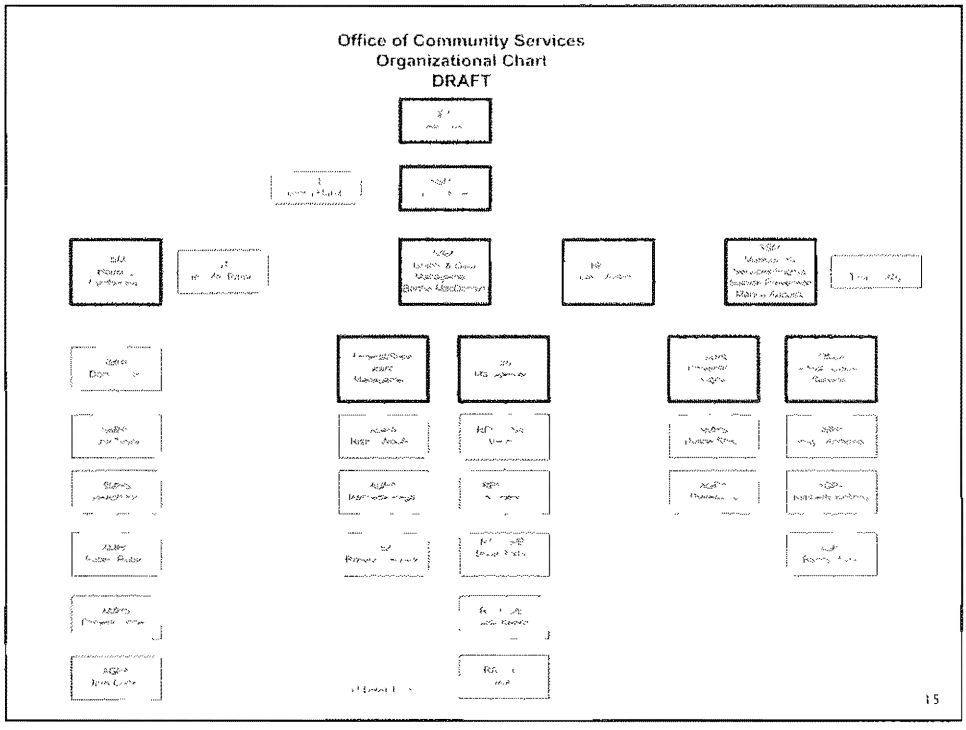

Conference Compromise Detail Sheet
Department of Mental Health = $8.805 m

Total of 19 Positions as follows: $1.941 million Total
$1.193 Salaries + $447,000 benefits + $300,000 Operating Expenses

1. Housing – 7 Positions

Staff Mental Health Specialists (2.0)
Staff Services Manager I (1.0)
Associate Governmental Program Analyst (3.0)
Office Technician (1.0)

2. Suicide Prevention – 3 Positions

Associate Mental Health Specialist (1.0)
Staff Services Manager I (1.0)
Associate Governmental Program Analyst (1.0)

3. Stigma Mitigation – 4 Positions

Health Education Consultant III (1.0)
Staff Mental Health Specialist (1.0)
Staff Services Manager I (1.0)
Associate Governmental Program Analyst (1.0)

4. Focused Data Analysis – 5 Positions

Career Executive Appointment (1.0)
Research Program Specialist I (1.0)
Research Analyst II (1.0)
Staff Mental Health Specialist (1.0)
Office Technician (1.0)

Conference Compromise Detail Sheet
Department of Mental Health = $8.805 m (cont.)

B. Contract Funds: $6.864 million

1. CA Network of Mental Health Clients — $268,000 (existing level)
2. National Alliance on Mental Illness — $283,000 (existing level)
3. Office of Multicultural Services' Contracts — $1,959,000 (existing level)
   (includes: $1.5 m Reduce Disparities at existing level, translation services, etc.)
4. CA Institute for Mental Health — $4,144,000 (less than)
5. United Advocates for Children and Families — $210,000 (existing level)

DMH Functions Today

Functions	LOCAL	DMH	MHSOAC	CMHPC	DHCS	ADP	CalMHSA	Other / State Agency
Financial Oversight								
Issue Resolution								
County Data Collection & Reporting								
Housing								
Suicide Prevention								
Student Mental Health Initiative								
Stigma & Discrimination								
Multicultural Services								
Caregiver Resource Centers								
Co-Occurring Disorders								
Veterans Mental Health								
Disaster Response								
Early Mental Health Initiative								
SAMSHA Block Grant								
PATH								
Workforce Education & Training								
Training Contracts								
Technical Assistance								
Access / Utilization								
Program Evaluation								
Compliance/ Quality Improvement								
Other _____								

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Stakeholder Reflections

Stakeholder Reflections

Based on today's presentation, what are the changes in mental health at the state level that stand out for you?

Guiding Principles for Input

MHSA General Standards

- Community Collaboration
- Client and Family Driven
- Cultural Competence
- Wellness, Recovery and Resilience Focused
- Integrated Services Experience

Guiding Principles for Stakeholder Input

- Improve access to culturally appropriate services
- Improve quality of care
- Improve state accountability and outcomes
- Improve efficiency and effectiveness of community mental health system
- Include realistic implementation strategies taking into consideration available resources
- Fulfill organizational/policy/legal/statutory responsibilities

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Tips for Participation

- Listen, don't worry about what you want to say and miss the good words of others.
- Don't repeat what has already been said. Share a brief sentence of support if you feel you need to say something.
- Write down your thoughts, read your statement, then offer your notes to the facilitator.

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Small Group Break-Outs

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Break-Out Question #1

Based on what you heard today, what opportunities do you see as a result of the transition at the state level?

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Break-Out Question #2

Review Mental Health Functions Handout

Which entity should assume responsibility for the functions/programs listed?

What functions/programs are missing from the list?

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Small Group Summary

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Large Group Question

What do you believe are the challenges associated with the changes to mental health at the state level?

How can these challenges be addressed?

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Next Steps

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What will come of this stakeholder process?

- Stakeholder comments and input will be compiled into a comprehensive report for DMH
- DMH will host a statewide webinar to report back to stakeholders on the themes from the Community Mental Health Stakeholder Meetings
- A summary of stakeholder input will be provided by DMH to the public in October 2011

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Want To Know More?

- Please visit the Medi-Cal Transfer, Stakeholder Summer 2011 and Realignment Information webpage:

www.dmh.ca.gov

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Contact Information

CA Department of Mental Health

CommunityMHStakeholder@dmh.ca.gov

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CALIFORNIA DEPARTMENT OF Mental Health

2011 COMMUNITY MENTAL HEALTH STAKEHOLDER SUMMER SERIES

COMMUNITY MENTAL HEALTH FUNCTIONS

Functions	LOCAL	DMH	MHSOAC	CMHPC	DHCS	ADP	CalMHSA	Other / State Agency
Financial Oversight								
Issue Resolution								
County Data Collection & Reporting								
Housing								
Suicide Prevention								
Student Mental Health Initiative								
Stigma & Discrimination								
Multicultural Services								
Caregiver Resource Centers								
Co-Occurring Disorders								
Veterans Mental Health								
Disaster Response								
Early Mental Health Initiative								
SAMSHA Block Grant								
PATH								
Workforce Education & Training								
Training Contracts								
Technical Assistance								
Access / Utilization								
Program Evaluation								
Compliance/ Quality Improvement								
Other _____								

2011 COMMUNITY MENTAL HEALTH STAKEHOLDER SUMMER SERIES

COMMUNITY MENTAL HEALTH FUNCTIONS

Description of State Agencies and Governing Bodies

Department of Mental Health (DMH) – The Department of Mental Health was previously responsible for all of the activities listed on the State Mental Health Functions document. However, due to the reduction in staff, it is no longer capable of performing all the tasks listed.

Department of Alcohol and Drug Programs (ADP) - Administering prevention, treatment, and recovery services for alcohol and drug abuse and problem gambling

Department of Health Care Services (DHCS) - Financing and administering a number of individual physical health care service delivery programs, including the California Medical Assistance Program (Medi-Cal), California Children's Services program, Child Health and Disability Prevention program and Genetically Handicapped Persons Program.

Mental Health Services Oversight and Accountability Commission (MHSOAC) - Oversee the public mental health system and the Mental Health Services Act, including evaluating outcomes for clients and the mental health system, providing technical assistance to counties as needed, and developing strategies to overcoming stigma and reducing disparities.

California Mental Health Planning Council (CMHPC) - Mandated by federal and state statute to advocate for children with serious emotional disturbances and adults and older adults with serious mental illness, to provide oversight and accountability for the public mental health system, and to advise the Administration and the Legislature on priority issues and participate in statewide planning.

California Mental Health Services Authority (CalMHSA) - an Independent Administrative and Fiscal Governments Agency focused on the efficient delivery of California Mental Health Projects. Member counties jointly develop, fund, and implement mental health services, projects, and educational programs at the state, regional, and local levels.

2011 COMMUNITY MENTAL HEALTH STAKEHOLDER SUMMER SERIES

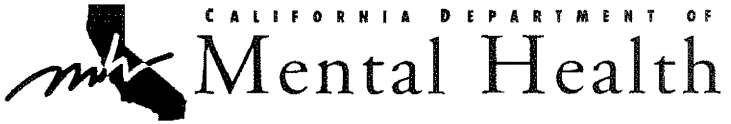
COMMUNITY MENTAL HEALTH FUNCTIONS

Local

- County mental health and behavioral health departments - Administer and implement public mental health and behavioral health programs and services.
- Local mental health boards and commissions
  1. Advise local mental health departments and Boards of Supervisors about community mental health needs as well as evaluating programs and services.
  2. Review and comment on county performance indicator data and communicate their findings to the Planning Council.

Other State Departments (examples):

- California Department of Education (CDE)
- California Department of Social Services (CDSS)
- California Department of Rehabilitation (DoR)
- Office of Statewide Health Planning and Development (OSHPD)



2011 COMMUNITY MENTAL HEALTH STAKEHOLDER SUMMER SERIES

COMMUNITY MENTAL HEALTH FUNCTIONS

Mental Health Functions Reference Summary

(In order of Appearance on Mental Health Functions Worksheet)

Financial Oversight
DMH was responsible for the distribution of MHSA funds for all components to county mental health departments. Counties still frequently contact DMH with questions about their distributions. Additionally, DMH is responsible for developing/monitoring the Revenue and Expenditure report to track reversion.

Issue Resolution
DMH receives MHSA issue complaints verbally and/or in writing and refers them to the county of origin, the Ombudsman, Patients Rights, Medi-Cal, or other appropriate agencies. DMH facilitates the issue resolution process among affected parties and produces summary letters of determination of outcomes to issue filers, counties, the Mental Health Oversight and Accountability Commission and the Mental Health Planning Council.

County Data Collection & Reporting
DMH is responsible for data collection from the Consumer Perception Survey (CPS) which is completed by consumers receiving case management, day treatment, and medication services at county-operated and contract service providers in the state.

DMH is also responsible for the Data Collection and Reporting (DCR) System which provides information about the outcomes across eight key quality-of-life domains (housing, employment, education, criminal justice involvement, legal designations, co-occurring disorders, etc.) for individuals enrolled in Full Service partnerships. Finally, DMH is responsible for the Client Services Information (CSI) System, which collects client demographics, service information, and periodic client-related information updates.

Housing
Funds, set aside for MHSA housing projects and administered by California Housing Financing Agency (CalHFA), are provided for counties to use to develop permanent supportive housing for persons with serious mental illness who are homeless or at-risk of homelessness. The funds are available for capital or operating subsidies.

2011 COMMUNITY MENTAL HEALTH STAKEHOLDER SUMMER SERIES

COMMUNITY MENTAL HEALTH FUNCTIONS

Suicide Prevention
The Office of Suicide Prevention (OSP) serves as a statewide resource center on suicide prevention in California and provides technical assistance and subject matter expertise for state and local partners. Serves as liaison with national partners (including SAMHSA, Suicide Prevention Resource Center, American Association of Suicidology, National Suicide Prevention Lifeline, and other state suicide prevention program coordinators) and facilitates a forum for information sharing for accredited suicide prevention crisis centers.

Student Mental Health Initiative
The Student Mental Health initiative collaborates with the California Department of Education and California Community Colleges Office of the Chancellor to address student mental health needs in the k-12 system and the community college system through a MOU with the two agencies.

Stigma & Discrimination
The Stigma and Discrimination program provides subject matter expertise for state and local partners, and maintains a Stigma and Discrimination web site. Provides technical assistance on the California Strategic Plan, disseminates it, and monitors its implementation

Multicultural Services
The Office of Multicultural Services provides leadership direction to the Department of Mental Health and stakeholders for identifying and addressing disparities in mental health as well as promoting culturally competent policies and practices at both the state and local levels. The Office of Multicultural Services also focuses on working with community partners and county Cultural Competence Ethnic Services Managers to eliminate racial, ethnic, cultural and linguistic disparities in access and quality of care within mental health programs and services.

Caregiver Resource Centers (CRCs)
DMH administers contracts for 11 regional CRCs that provide services to families whose loved ones are suffering from degenerative cognitive disorders that affect adults.

Co-Occurring Disorders
Effort between DMH, the Department of Alcohol and Drug Programs, and the Co-occurring Joint Action Council to find effective ways to treat alcohol and drug dependency co-occurring with mental health issues.

COMMUNITY MENTAL HEALTH FUNCTIONS

Veterans Mental Health
Provides subject matter expertise and technical assistance on veterans' mental health and works collaboratively with California Department of Veterans Affairs and California Military Department/CA National Guard.

Disaster Services and Response
When the President declares a major disaster in the State of California, certain programs can be approved and funded including the Crisis Counseling Programs (Immediate Services Program and Regular Services Program). Both are federally funded grants that are awarded to counties through the state. Currently, DMH's Disaster Services Unit has the direct responsibility of working with the interested impacted counties in preparing both grant applications. The Immediate Services Program grant has a very short application window of 14 days following the Presidential declaration, and the Regular Services Program has an application deadline of 60 days following the Presidential declaration. Cal EMA has fiscal oversight while DMH administers the programs. This is a very important program that assists disaster survivors with coping with the impacts of a disaster both in the immediate aftermath of an event as well as longer term impacts.

Early Mental Health Initiative
The Early Mental Health Initiative Program awards Early Mental Health Initiative (EMHI) matching grants to Local Educational Agencies (LEA) to implement early mental health intervention and prevention programs for students in kindergarten through third grade. Grant funding is provided for one three-year cycle to publicly-funded elementary schools, serving students in kindergarten through third grade who are experiencing mild to moderate school adjustment difficulties. EMHI provides services that are school-based, low cost, and are provided in a culturally competent manner.

SAMSHA Block Grant
The Center for Mental Health Services (CMHS) provides grant funds to establish or expand an organized community-based system of care for providing non-Title XIX mental health services to children with serious emotional disturbances (SED) and adults with serious mental illness (SMI). States are required to submit an application for each fiscal year the State is seeking funds. These funds are used to: (1) carry out the State plan contained in the application (2) evaluate programs and services, and (3) conduct planning, administration, and educational activities related to the provision of services.

California acts as a "pass-through" agency, receiving federal funds and allocating them to counties through a formula. DMH receives approximately $53M for the implementation of the Block Grant Program.

COMMUNITY MENTAL HEALTH FUNCTIONS

PATH (Projects for Assistance in Transition from Homelessness)
In accordance with the Public Health Services (PHS) Act, the PATH program provides funds for specialized community-based services for persons with serious mental illness and co-occurring substance abuse disorders who are homeless or at imminent risk of becoming homeless. This program is state administered and locally-operated by the county or through county sub-contractors. California receives approximately $9M in federal grants for the implementation of this program.

Workforce Education & Training
DMH administers 24 contracts that provide loan repayments to individuals, stipends to mental health professionals, funds for psychiatric residency programs, an added mental health track to physician assistant programs, and assistance to consumers and family members to become fully integrated into the public mental health workforce, and bring county mental health departments, educational institutions, and community-based organizations together to meet regional workforce needs. These contracts are driven by the needs assessment for which DMH also contracts and the stakeholder-developed and Mental Health Planning Council approved Five-Year Plan

Training Contracts
DMH has contracted with CIMH to provide training to counties as they implement the MHSA components. CIMH works with stakeholders in the mental health services to educate counties to identify best practices, share knowledge, and develop training tools.

Technical Assistance
Technical assistance for the MHSA Housing Program is frequently requested by counties as they develop housing projects. As more projects are nearing completion, the technical assistance will be more focused on assisting counties with questions related to housing supports and property management.

Program Evaluation
Prior to the passage of AB100, DMH reviewed plans and could offer technical assistance to counties and providers. In addition, DMH contracted with public research organizations such as the U.C. Berkeley Petris Center for Full Service Partnership Outcomes and the External Quality Review Organization (EQRO) to conduct program quality evaluation.

Compliance/ Quality Improvement
DMH conducts comprehensive program and fiscal audits of county mental health programs and mental health providers with the goal of ensuring compliance with statutes and regulations as well as identifying opportunities to improve quality and optimize patient care.

Appendix II

Notes from Sacramento Kick-Off Stakeholder Meeting August 2, 2011

CALIFORNIA DEPARTMENT OF Mental Health

2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES
DATE: August 2, 2011 LOCATION: Sacramento, CA

Participants

17 Consumers/Family Members/Consumer Advocates
17 Providers
10 County Representatives
34 Other
181 Phone Participants
259 Total Participants

Pre-Meeting Education Session- Questions/Comments

- The use of realignment language is confusing due to Realignment 1 (1991). The current effort is "realignment of approval to local level"
  - AB100 = changes in plan review responsibility more efficient way to provide input into county plans.
- AB100 Workgroup is determining oversight functions.
- A102 outlines Administrative functions
- DHCS does Medi-Cal oversight for whole system; the move to DHCS houses ALL functions to one entity.
- What happens when you have services and programs with a mixture of funding streams (including M/C)?
  - Funding is blended but the intention of funding streams causes confusion/challenges
- Recovery principles are critical, but they are not a part of the medical model of services.
- What happens to the WET contracts administered by DMH (e.g., CalSWEC)?
- What considerations are being made with data collection (M/C claims, etc.)?
- It make sense to realign to local level only if locals know what they are doing:
  - Rural – not as big of base of history with MHSA
  - Knowledgeable staff retire/attrition
  - Reluctance to hire consumers
- There are unique challenges for small counties.
- This change (transfer of Medi-Cal) is centralizing a function that has been sub-contracted to DMH.
- Blended funding used to maximize resources; does not necessarily mean that the transfer to DHCS will change the program/intention
- Blending funding in counties:
  - Funding drives programs
  - Reversals to other types of services as resources/funding go down

Please note: Stakeholder questions appear in black font, DMH response indicated in red font

2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES
DATE: August 2, 2011 LOCATION: Sacramento, CA

Stakeholder Process and Design Input

- Where does the MHSOAC have a role?
  - MHSOAC = oversight & accountability and technical assistance
- Oversight is a huge issue that needs to be discussed and determined.
- The functions handout is a [partial] list of functions that are "left over" Community Services Division (DMH) functions/activities/programs.
- Compliance reviews also look at Realignment structures, Boards/Commissions
- Mental Health Functions Handout:
  - People in the counties won't know what is happening/function at the state level (providers might know).
  - Un-served communities will not want to fill out his handout at the local level
  - People want to be asked, "what is important to you?" or "what do you want/expect from the state to help at local level?"
  - What do we want the partnership to be between the county and the state?
- Continuum of Education:
  - What are you asking stakeholders to make a decision on?
  - Community and consumers – what are they needs from the unserved and underserved communities
  - After education (down the road), there is not enough time to do this today
- Be more direct to say what steps should/are being implemented to protect existing programs like the California Reducing Disparities Project.
- Performance contract monitoring is the charge of MHSOAC:
  - Across the lifespan
  - Adherence to MHSA values

General Stakeholder Session- Questions/Comments

- This is a cumulative stakeholder process and full participation can be a burden for organizations with limited budgets. Are funds available to support travel?
- George Hills/CalMHSA should be included in this stakeholder process.
- Regarding the schedule, will there be a "regional" stakeholder meeting in Sacramento?
- Office of Consumer and Family Affairs is a function that should be included, as well as:
  - State Quality Improvement Council
  - Compliance Advisory Council
  - Client Family Taskforce
- These are profound structural changes; you need to engage as many stakeholders as possible:
  - Auditorium setting make people comfortable
  - Consider smaller groups to allow more participation

Please note: Stakeholder questions appear in black font, DMH response indicated in red font

- Mental health and substance abuse continue to be "ugly ducklings". We need to continue to pay attention to MH and SUD in the context of integration. There are further disparities in access and quality of care.
- Licensing/certification missing from the functions list.
- It would be helpful to know more about what DMH does well; think about not transferring those functions that DMH has succeeded with.
- Central leadership on terms of policy; statewide focus to maintain standards of MHSA.
- There needs to be statewide oversight of local planning processes.
- Providing interpreters is not the only aspect of cultural competence:
  - the venue/parking/location not friendly for communities
- Who are the target populations for these meetings? How does this activity improve care for people in the communities (especially for racial, ethic, linguistic, cultural groups)?
  - One month of meetings is not enough time. It takes time to prepare people from unserved and underserved communities to participate in this type of stakeholder process.
  - Get local people who are already working with unserved and underserved populations to help with outreach
- Challenges:
  - Co-occurring disorders
  - Stigma and discrimination
  - Unique characteristics of the service system
    - Client family driven
    - Cultural competence
- The CA Mental Health Planning Council recommends a stand alone mental health department that reports to CHHS.
- Mental health parity—there are too many clients/caseload issues in the system
- Need to consider health care reform, integrated services, and systems of care
- Use of MHSA funding created a dual system. No one is answering stakeholder questions about this issue. When is MHSA going to be integrated?
- There are challenges for family members, like getting to meetings. There are transportation and child care issues. Will there be options or stipends so that family members can attend the meetings?
- Family voices need to be heard – we need to think more about how to ensure participation
- Need to continue state level oversight and accountability to ensure counties addressing stakeholder concerns/needs
- Cultural competence: we need to include African Americans.
- Cultural competence/strategies to engage:
  - There are [more than] 80 federally recognized tribes with their own governments
  - There are no evidence based programs for Native peoples

  - We need to focus on engaging California's Native American tribes/people in this stakeholder process
- Concerned about the limitation of choosing only (5) priority area/functions need to preserve more than five.
- OMS just got started with the CA Reducing Disparities Project
- Housing is essential, especially with issues around federal funding decreasing
- State quality Improvement Council
- Data Quality and Improvement
- Compliance Advisory Council
- Lack of oversight stands out
- In the past, when counties were not being inclusive of Native Americans, we had a place to go: DMH. What will happen now?
- It takes time to get people to Stakeholder meetings
- Why is a meeting in Bay/Oakland/San Francisco not on the schedule?
- AB100 has an opportunities for reducing disparities.
- How do we meet the intentions of MHSA when the focus of services is on Medi-Cal? The funding is not there to support the goals of the MHSA.
- We need to address Prevention and Early Intervention.
- Will DMH be posting materials online? Including a transcript of the meetings?
- Office of Multicultural Services
  - Chief of OMS position needs to be restored
- It will be a good idea to engage unserved and underserved groups by speaking directly with the CRDP contractors:
  - Strategic Planning Workgroups
  - CA MHSA Multicultural Coalition
- Who is "the State"?
- Oversight is the most important state function
- Training and technical assistance needs to be provided to counties struggling with MHSA requirements
  - Include clients in the training – bring a perspective that is not always addressed.
- Local level needs to provide opportunities for inclusion of communities. The counties have to makes themselves open to that inclusion.
- MHSOAC adopted principles for oversight at the July 28th Meeting, the document is available online.
- A benefit of this transition is getting services to consumers faster. A challenge will be the [potential] continuation of money for ineffective programs [look at outcome and results].
- Transition Age Youth
- Which functions are necessary to meet federal requirements?
- There are a lot of functions on the list that are not just MHSA functions (OMS, etc.)
- Using Realignment terminology is confusing – not all aspects of Realignment II have passed

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

- Rebooting commitment to transformation, we can't let this opportunity to pass by. We need structure and leadership at the state level to keep it going.
- Juvenile justice – what is the role?
- Have regulations been modified to align with AB100?
- You are missing a whole segment of consumers and family members without access to computers; meeting notices could be posted at local pharmacies [as one additional avenue to reach out to stakeholders].
- There is no safety net for consumers. 911(not always a good option) Adult Protective Services (not always a good option)
- Early Mental Health Initiative (EMHI) is a priority and needs state oversight
    - Data is available to demonstrate effectiveness of the program
- Oversight and accountability at the state level
    - Look at findings of CRDP Reports
- Speaking as a family member with family only receiving Medi-Cal services money, we need to prioritize the following:
    - Older Adults
    - Integrating the system – MHSA
    - Out of county placements

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

Appendix III

Notes from Butte County Regional Stakeholder Meeting August 8, 2011

CALIFORNIA DEPARTMENT OF Mental Health

2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES
DATE: August 8, 2011 LOCATION: Chico, CA

Participants

10 Consumers/Family Members/Consumer Advocates
20 Providers
16 County Representatives
07 Other
24 Phone Participants
77 Total Participants

Based upon today's presentation, what are the changes in mental health at the state level that stand out for you?

- Counties are dependent on MHSA funds, how will MHSA funds be allocated?
- What kind of advocacy for Older Adults will exist for Aging Community as a result of the elimination of the Department of Aging?
  - [What will be the] representation at the State Level?
- With MHSA the consumer/family voice was heard at the state level, [I am] worried that consumer/ family member voice will be "squashed" again.
- Is the report relevant to African American community? How?
  - What will happen to the African American CRDP Population Report and all the strategies the community defined as a best practice to bring them to wellness?
  - Worried about the relevancy of the report if it just sits on the shelf and none of the community defined evidence is implemented and evaluated.
- I am concerned about the elimination of the Office of Multicultural Services. It needs to continue.
- Programs/functions to be transferred to the county level, but is funding going to the counties to support the work. Will there be training/information for stakeholders?
- Housing component will stay at DMH, but CSH funding/contract is not available. How will Housing continue without them? I am worried about continued technical assistance. I hope that the Housing programs will continue to be supported.
- Can DMH create a chart that shows the proportion the proportion of DMH resources (staff, budget, etc.) that supports the function? It will help stakeholders to make decisions about the functions.
- Concerns around California Reducing Disparities Project and where it will go and what will come of the reports each Strategic Planning Workgroup is completing right now. We want it to continue and ultimately make a difference.
- Youth/TAY will inherit whatever the changes are that made now. It is a good time to involve youth, so that youth have more opportunities.
- Continue to support employment for consumers/family members.
- What about the Office of Patient's Rights? Will it be moved?

CALIFORNIA DEPARTMENT OF Mental Health

2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES
DATE: August 8, 2011 LOCATION: Chico, CA

What opportunities do you see as a result of the transition at the state level?

Consumers/Family Members/Consumer Advocates

- More local control with focus – hopefully with local Mental Health Boards and Commissions.
- Parity – mental health aligned with health care
- More opportunities for collaboration with PIER
  - -PEER Recovery Model
  - -If at the local level, it may help voices be heard.
- Accessibility is important – Accessibility and communication of services/issues/information
- Budget transparency = knowing where every dollar is going
- More partnerships with Aging groups and regional centers
- Need and opportunity for accountability within communities
  - -People working together, not relying on state
  - -Empowers community to improve
- More opportunities for youth engagement
- Consumer dialogue with the State – How do we keep the consumer voice at the state level?
- Opportunities for cultural competency, offer more opportunities for diverse populations.
- Opportunity to engage stakeholder directly
- Togetherness
- Pay attention to youth issues – racial, queer justice, liberation as it intersects with mental health
- Who will speak for community in the new reality?
- Realistic measurement based on communities needs that will drive services.
- Chance to "get it right!"
- Opportunity for others to come to the table to provide input
- Want to ensure racial disparity reports get seen and acted upon
- Integrated system

County Representatives

- Consumers want to affect policy at higher level. Whom do they go to influence policy?
- Bringing enforcement/documentation in-house is a good opportunity. We are spending time trying to anticipate auditors (gathering documentation, treatment plans). It would be wiser to spend time seeing clients and not worry about documentation standards.
  - Base documentation on Medicaid [or other] Federal standards to make it simpler
  - Consumer driven or case-manager driven efforts for documentation.
- Counties spend too much time re-interpreting DMH Information Notices. This is especially challenging for small counties. Control is the heart stone over MHSA, get oversight to the local level. Make sure funds are kept at the local level.
  - More organic process – opportunity to really hear from county boards. Break open "cubbies" of requirements
- There are a tremendous number of functions now at DMH – concerned something will fall through the cracks.
- Stigma Reduction should stay at state level. Funds available at state level, Counties don't have funds for advertising.

- Streamline extra bureaucratic layers that use up funds
- Pot of MHSA funds will get smaller, [we need to find] a fair and equitable way to split funds to counties. Not all of the money should go to Los Angeles, smaller counties are concerned.
- Timely payments to counties
  - Baseline vs. caseload growth
  - Cost settlements distribution-can't float the funds.
  - Locals pay their bills on time. Why doesn't state pay in timely manner? MHSA is fine, but [I am] concerned about Realignment
- Opportunity for relationship between county and state – to clarify the relationship. More cooperative – less enforcement.
- Protections so that counties don't redirect funds if they don't think mental health is important.
- There is a concern that counties will get told, "you shouldn't have done that" after services have been provided rather than receiving the "blessing" before services begin.
- Fiscal regulation is a very hard process. If it hadn't been so difficult, reversion wouldn't have been a problem. Reversion worked against counties due to the strict regulatory requirements of DMH.

Providers

- Integrate services with a balanced service delivery model. In other words, don't have more resources going to one type of service more than another.
- Reduce paperwork/eliminate duplication
  - Outcomes/billing/AVATAR
- Services to full family → not just the client but a full array of services for the family as well.
  - Local Option
- Decision making authority at the local level
- Diversity across family and systems
- Statewide – continue funding and programs
- The Housing program should stay with DMH for oversight
  - Streamline communication
  - Long term program
  - Supportive services

CALIFORNIA DEPARTMENT OF Mental Health

2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES
DATE: August 8, 2011 LOCATION: Chico, CA

What do you believe are the challenges associated with the changes to mental health at the state level? How can these challenges be addressed?

- Make sure things don't fall through the cracks.
- Maintain institutional memory of how things happen (i.e., DMH and system in general), this is not the first time that there has been major change. What will happen to people in poor communities? There is some ongoing memory of what is happening right now, some continuity of history.
- History of cross training with county and CalHFA, maintain the momentum of affordable housing – maintain network and partnerships, knowledge may get lost.
- When we talk about challenges we have to be realistic and remember that there is going to be havoc.
- Keeping alive the core of the things we learned through MHSA will help us through this transition.
- How to make the change work: keep hope alive, positivity, look to the future.
- Maintain some oversight: educational rather than punitive with clear expectations.
- Getting stuck and blaming the state- we need to start building community accountability.
- Continuing state and local collaboration.
- Focus on collaboration across regions to include people outside the public mental health system.
- One of the challenges is to be thoughtful about how we maintain the integrity of behavioral/mental health
- Combine similar functions across state agencies. Cross train at the state agencies to perform the function. Eliminate the silos to help reduce stigma and discrimination.
- Don't forget the providers and clients. Continue to inform them, keep them "in the loop" through full inclusion and communication.
- It will be a challenge to advocate for mental health programs that will be integrated. No single voice.
- [Stakeholder meeting] notices need to be sent out earlier. Maybe have opportunity to get information from this region.
-

Appendix IV

Notes from Napa County Regional Stakeholder Meeting August 12, 2011

CALIFORNIA DEPARTMENT OF
Mental Health

2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES
DATE: August 12, 2011 LOCATION: Napa, CA

Participants

04 Consumers/Family Members/Consumer Advocates
06 Providers
07 County Representatives
01 Other
12 Phone Participants
30 Total Participants

Pre-Meeting Education Session- Questions/Comments

- Is consideration being given to health care reform (i.e., expansion of Medi-Cal population)?
- New opportunities for parity
- What is the potential for lost opportunities?
- How will statewide efforts around person centered treatment planning be affected by the Medi-Cal transfer? Current efforts are more aligned to MHSA.

Background and Context Questions/Comments

- With the reduction of staff, was that funding passed to the local level? Yes
- What kind of influence does this stakeholder process have on actual decisions made? The summary report will include stakeholder input and will be considered by the Legislature and Governor.
- What does CMHPC stand for? CA Mental Health Planning Council
- What is the difference between DMH and CMHPC? DMH = Administrator CMHPC = Oversight Body
- NAMI = National Alliance on Mental Illness. They recently changed the name in order to reduce stigma.
- Federal carve-out of funds: What is the role of these function/programs? Functions still a part of the existing Role of DMH (PATH Grant, etc.) This process will help determine where these functions should be housed. DHCS or (joint ADP and DMH) Department of Behavioral Heath?

Based upon today's presentation, what are the changes in mental health at the state level that stand out for you?

- Great opportunity for a paradigm shift → partnership with local county and clients/family/communities
- Local control of services. State/federal uniformity
- Shifting responsibilities is both an opportunity and risk – local fairness is an issue.
- Local control means less bureaucracy and more efficiency.

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

- Concern that local stakeholders may not know enough about state level functions to make informed recommendations
- Is there any opportunity to re-evaluate policies and regulations to make programs and funding more adaptable to local level (i.e., requirement of 51% of FSP funds allocated to children/youth)?
- Concern about fairness and "statewideness" – measurement of impact of programs/services statewide, sharing best practices, outcomes
- There is concern about funding distribution
- AB100 = "State will perform x functions" but who is "the State"
- There are resources and AB100 helps us to navigate that
- Will Orange Co get more money? There is an existing funding allocation formula, it will not change as a result of this transition process
- Will State legislators still listen to local stakeholder input without support of state DMH? Yes, there is a commitment to on-going stakeholder input, the MHSOAC and CMHPC also provide this support to stakeholders.
- Shared responsibility – work more closely with local programs and providers not either/or but and (shared functions)
- Older adults are historically unserved in the nation – is that information being considered. Napa = large population of older adults
- Concerned, in this transition that we might lose a statewide voice and advocacy in Administration. Maintain a strong statewide voice in light of healthcare reform to work with the Feds to keep mental health in the discussion and prevent our folks from becoming more invisible. DHCS is aware of these concerns. There are several proposals:
- Create a new Department of Behavioral Health
- Executive level Administrator parallel to DHCS Director to represent Behavioral Health
- Other options are also being considered

What opportunities do you see as a result of the transition at the state level?

Consumers/Family Members/Consumer Advocates

- Find out what are other states doing regarding government reforms
  - It feels like health plans only want to do the minimum
  - ADP and Mental Health were pulled out to get more attention and that might get lost.
  - CalMEND
  - Opportunity to have early intervention especially at schools
  - To create navigation systems for clients within systems
  - Opportunity to work together collaboratively
  - More local (unique) control
  - Mental health has often been missed, an opportunity for advocacy is now possible
  - MHSA has resulted in funding cuts to local pre-existing programs
  - Individuals need to help make a difference – not just millionaires.
  - Data collection has been a large problem at DMH, making it hard to justify needed funding.

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

County Representatives

- Strengthening local Departments through simplification of Administration systems – counties spend a lot of time explaining processes to our consumers.
- Health, Drug and Mental Health Medi-Cal alignment provides an opportunity to facilitate better integration [of services].
- Opportunity for aging clients whose primary diagnosis may change over time. There may be an opportunity to continue to provide mental health services for that client and bill Medi-Cal.
- Dual diagnosis and the continuum of care
- Integration of services means more access, no wrong door.
- Within community health clinics, there is a concern about physical healthcare trumping everything. Is there a way to stage it so that specialty mental health services don't get lost?
- We can't really help people with transportation between PCP to MH; this transition may lessen silos.
- There are many circumstances in which Medi-Cal population is misaligned– confusion between payment with county of placement, county of residence, county of Medi-Cal responsibility- cross county services can be improved with Medi-Cal integration.
- There could be opportunities to streamline data collection and reporting requirements.
- Provider communication increased between primary care physicians and mental health clinicians.

Providers

- Simplification/reduction in redundancy
- Bottom up planning
    - More responsive planning
    - Counties are the experts
- Tighter link between community needs and county response may lead to more customized/ pilot programs/creative intervention programs/innovative programs
- There is concern about funding being combined/less allotments to the individual state agencies.
- Combined billing systems can result in faster return of funds.
- Same day billing issues
    - The billing system should not drive services
    - Don't make the client have to come back another day
    - There is an opportunity to consider a healthcare reform model that addresses this concern
- Opportunity within Medi-Cal Realignment:
- Aging clients and changing diagnosis can still be covered during these transitions
- In an integrated health system, need to make sure that people don't drop through the cracks.
- Having everything under one umbrella may help fill gaps in care (e.g., Alzheimer's treatment)

Phone Participants

- There is the possibility of more integration of mental and physical healthcare services.
- The process of drawing down MHSA funds could be streamlined and made less onerous.

Which entity should assume responsibility for the functions/programs listed? What functions/programs are missing from the list?

County Representatives

- What does financial oversight entail?
- Federal funding released to counties
- County plan review (i.e., PATH program)
- MHSA funding distribution
- There should be an integrated reporting mechanism.
- Will this exercise inform what DMH will be in the future, assuming that DMH will be eliminated or morphed?
- To maintain "statewideness" there should be a single Behavioral Health entity.
- Statewide Prevention and Early Intervention projects should be kept together.
- Federal block grants stay together with all mental health program functions (maybe with Department of Healthcare Services and Medi-Cal programs)
- Unless CSI system will change, it makes sense to have counties report this data to one entity with a unified data set and one way of reporting.
- Wherever this information lives (data) there has to be a uniform/shared system so that everyone (all State entities) can have access to this information merged reporting system.
- It is important to create opportunities for counties to extract and utilize data.
- The State should build opportunities to have housing funding blended or merged to have a bigger pot of available funds for housing programs.
- Training and technical assistance could go to CalMHSA; especially if CalMHSA grows as an entity and assumes a larger role/responsibility.
- One reporting system would better support healthcare integration.
- The most important thing is shared responsibility/partnership with local level.
- The majority of counties shave joined CalMHSA , they are the statewide representative of counties.

Providers

- Are there diverse members on the CA Mental Health Planning Council? Is there Native American representation?
- Is DHCS expanding rapidly?
- Does CalMHSA provide services or do they just do policy work?
- Do we know what financial support is allocated for each function?
- There needs to be oversight to ensure fairness across the lifespan.
- Are we [the state] dispersing funding fairly? Historically, we have seen an imbalance.

- Where at the state level is there oversight for MHSA?
- Will future funding be guaranteed?
- We need local authority for financial oversight. However, there is a risk of corruption and lack of oversight.
- The fairness vs. efficiencies issues is long standing.
- The state took a long time to review plans and money took a long time to get to counties.
- How will (non DHCS/Medi-Cal) audit/compliance issues change?
- Will EQRO continue? Does DHCS have an outside/external reviewer?
- Data Collection function:
- Will DMH analyze county data? Who will analyze the data?
- [Data analysis] needs to go statewide, similar to how the MHSOAC does statewide evaluation with UCLA.
- What are the stakes involved with data collection?
- If you don't report the Medi-Cal data, you don't get money.
- We should have one centralized location to report data so counties do less work and spend less time on reporting.
- Reduce the duplicated requirements due to different funding streams with different funding requirements.
- Think about performance outcome measures.
- Hold a stakeholder meeting to discuss how we should move forward with these functions.
- Housing should be at the local level.
- Suicide Prevention: Keep partnerships with DMH and CalMHSA (CalMHSA voting is weighted for large counties per population size).
- Caregiver Resource Centers:
    - Regulation consistency is critical
    - The funding should not go to the Department of Aging, but it needs state oversight.
    - DHCS would be a good option for oversight during healthcare reform transition.
- Multicultural Services:
- Need state level oversight: keep the Office of Multicultural Services at DMH
- Make sure the folks reviewing the Cultural Competence Plans are diverse and representative of the lifespan
- Veterans Mental Health: What supports does this have at DMH? Keep it at DMH because there are not enough resources.
- Suicide data omitted the highest % of suicide – aging population. We need to be at the table, let's not perpetuate the disparities.
- WET:
    - DMH isn't approving but keeps funding/stipends/statewide student stipends/etc.
    - CiMH did many WET webinars
    - WET left out the Aging population, this was a missed opportunity.

Phone Participants

- Stakeholders are being asked to decide where functions should reside, but in many cases, do not have sufficient background and knowledge of the current functions to make this decision. There are varying degrees of stakeholder knowledge and it is challenging to make a recommendation on the topic without adequate information.

- It would be helpful for the CA Department of Mental Health to identify what it believes to be essential functions to remain and the state level and which functions would not make sense at the local level.

Break-Out Themes

- Healthcare reform
- Continued focus on alcohol and drug services and mental health within new structure
- Stigma reduction and early intervention
- System navigators
- Integrated funding and billing
- Local control
- More collaboration with local stakeholders
- Data collection and reporting redundancy reduction
- More innovative/creative programs
- Same-day service option
- Simplification of Administrative function leads to efficiency
- Provider coordination: shared information, communication, improved continuum of care

What do you believe are the challenges associated with the changes to mental health at the state level? How can these challenges be addressed?

- Cross-cultural communication between state entities is a way to meet some of these challenges
- Continued stakeholder input
- Take time to learn about Mental Health, AOD, DHCS
- County communication/"cross-pollination"
- Clients worried about loss of benefits – they need reassurance to understand that resources/services will continue to be provided and this change not about benefits.
- Create a process on how to mitigate these challenges and include: clients, family, community, state, and local level entities.
- Establish a concrete problem-solving process
- There are too many unknowns regarding lack of budget/resources.
- Funds used for intended purpose
- Equality of opportunity and fairness
- Limited role of oversight (MHSOAC), there is a need to expand oversight have an entity to assume this function
- Not a good understanding of functions or roles of different state agencies
- What do counties do about guidance (i.e., existing regulation, policy, etc.)?
- Rule-making at state level lost, there are 58 different counties and they need clear guidance.
- Close attention should be paid to how local mental health programs are provided with information and communication. Lack of information and technical assistance inhibits counties ability to communicate. Some entities are new players to specialty mental health which will require these entities to learn and be open to county feedback/communication

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

- Keeping a recovery focus may be difficult as we move to DHCS. DHCS' knowledge and support of recovery principles is of great concern with local stakeholders.
- Healthcare is historically cost-focused not wellness focused.
- Prevention and Early Intervention funding is a state level funding source – we should not lose PEI focus.
- This could just lead to more entities to report to and more reporting requirements for counties.
- Stakeholders have limited background or knowledge about state level functions. What does DMH think are "essential" functions to remain at State level?

Phone Participants

- With Medi-Cal mental health functions transferring to DHCS, will there be staff with the mental health background and knowledge to perform these functions?
- Much progress has been made towards the "recovery model" and using recovery oriented language in the Medi-Cal system, but with functions transferring to DHCS, will this progress be lost? Will the recovery model be pushed back into a medical model?
- Oversight of MHSA funds needs to remain at the state level to ensure that counties are using the funds appropriately. This state oversight should focus less on paperwork and administration and more on quality and outcomes.
- Although there are general Medi-Cal rules and regulations on a statewide level, every county interprets them differently and has their own way of implementation (i.e. billing codes, client plans). Changes at the state level could lead to more variance across counties **or** it could be an opportunity to bring more cohesion and a standard way of interpreting rules and regulations across the state, which would be a benefit to clients and families.

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

Appendix V

Notes from Fresno County Regional Stakeholder Meeting August 16, 2011

CALIFORNIA DEPARTMENT OF
Mental Health

2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES
DATE: August 16, 2011 LOCATION: Fresno, CA

Participants

40 Consumers/Family Members/Consumer Advocates
12 Providers
11 County Representatives
17 Other
31 Phone Participants
111 Total Participants

Pre-Meeting Education Session- Questions/Comments

- Is the data collected from stakeholder meeting coming from consumers? The data is coming from counties, providers and consumers/family members.
- Some of the funding comes from federal funds, correct? Yes, there are several federal grant programs at DMH – where should they go?
- When are these changes going to take place? Transition plan due in October – changes will occur July 1, 2012
- The timeline is too short to get input on the changes
- If there are any changes to the services, how will that be noted and will stakeholders have input? We are not that far into the process, but there will be notification if any services will change.

Background and Context Questions/Comments

- The Governor previously tapped into MHSA money, with the consolidation, will we be able to track MHSA money / utilization? Yes, AB100 shifts money directly to county mental health
- Will the MHSA money going directly to counties offset realignment funds? No, it is added does not subtract.
- Quality of services for mental health and substance use disorders. One option being considered is to create one Department for both mental health and alcohol and drug programs
- Alcohol and drug services cannot be separated from mental health,I am very concerned about where these services will go.
- Prop 63 Prevention is equated with Intervention and not truly about prevention. Where will prevention (and funding for these services) go? We hope to have written input/suggestions into this topic, please tell us what you think should happen with these services.
- What will be the level of stakeholder consumer, family member input? Hopefully it will expand. DHCS is committed – I hope Prop 63 stakeholder input will improve and continue.
- In Fresno, the Alcohol and Drug Advisory Boards were not invited. It would be helpful to get info on co-occurring and if they were represented. ADP wanted to have separate meetings to ensure AOD stakeholders have an opportunity for input.
- Response to information about ADP stakeholder meetings: We can't know that the meetings are happening unless we look at the website and we don't know to look at the website if we don't know about the meeting.

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES
DATE: August 16, 2011 LOCATION: Fresno, CA

Based upon today's presentation, what are the changes in mental health at the state level that stand out for you?

- Communication between state and counties should not be diluted due to functions moving, communication needs to happen both ways.
- The [potential] coordination of Administrative requirements.
- With such huge staffing cuts, how is the work being processed? How are services able to be provided?
- I think DMH might be over-estimating the effectiveness of the Department with only 19 staff remaining.
- More discussion is needed about the service delivery implications. How will the unique situations of counties be taken into consideration? The state is no longer "micro-managing" services. This transition is moving the management of services to the local level which will increase services and quality at the local level.
- There is concern about mental health being lost entirely.
- There is a need to continue momentum of prevention, as well as disparities and discrimination against clients.
- We are also concerned about the fate of the Office of Multicultural Services:
  - Mental health knowledge and expertise
  - Cultural Competence Plan Requirements (CCPR); concerned that AB100/102 sets the stage for the elimination of the CCPR which is across funding streams (M/C and MHSA)
  - CA Reducing Disparities Project – hope to see funding continue

What opportunities do you see as a result of the transition at the state level?

Consumers/Family Members/Consumer Advocates

- Keep everyone involved
- No exclusion
- Bring more services to local level and meaningful services
- Learn new skills
- Get services more focused on recovery
- Get back responsibilities to local level
- Help to be more focus
- Community driven
- County priority and driven by county
- Cross training and education of other populations
- Education
- State encouragement for communication and cooperation
- Share and work together
- Work with local entities on integrative practices
- Regional academies for training
- There needs to be oversight to watch over mental health services
- Financial oversight usually brings control (power); the only leverage is through funding

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

County Representatives

- Don't blackball mentally ill people – provide a certification process that we can use to make a living.
- Fresno County has "Peer Support" positions that provide living wages and a routine.
- Improved access to medication for low income people.
- Anti-stigma campaign –more Public Service Announcements at the county level.
- By moving money to counties, there are more opportunity for services like employment and stigma.
- Co-occurring disorders
- Transitional-age-youth
- Cultural competence
- Early intervention
- There should still be financial oversight and accountability to the State. Locals should track finances, but there should be accountability at state level
- Issue Resolution: county should review first, then move to State oversight/accountability structure
- I am concerned DHCS doesn't really understand mental health; they need mental health knowledge.
- There is a problem with affordable services at local level.
- Regarding county data collection and reporting requirements, sometimes counties are reporting just to report. Locals should decided what data is important to track effectiveness
- Simplify and focus on the essentials. MHSA activities are established through the county planning process.
- Local control that's unique to the culture of the county.
- Local autonomy- counties can expedite services without State buy-in.
- More jobs for consumers and more "wellness centers".
- Incorporate practices that have been proven to help people become autonomous.
- Do not dilute funding by offsetting Realignment, this is a huge concern.

Providers

- With this transition, counties cannot move forward with various questions regarding Medi-Cal issues. It has been difficult to reach DMH and DHCS staff with questions.
- Funding to counties offers quantitative/qualitative services
- Less oversight from the State
- Strengthen Mental Health Boards and Commissions
- Unsure how services will be affected especially services with blended funds
- Eliminate redundancies in oversight/reporting requirement
- More coordination between agencies for reporting requirements
- Joint commission Audit shared locally? Audits through Department of Behavioral Health?
- DMH should be combined with ADP
- Enhancing Co-occurring services

Phone Participants

- More funding at the local level with less ties.
- Great opportunity for local mental health boards to be involved in the decision making process.
- Opportunity to collaborate with the military, veterans and their families, and to include them in mental health planning.

Which entity should assume responsibility for the functions/programs listed? What functions/programs are missing from the list?

Providers

- What happened to technical assistance for counties? Technical assistance is important for counties.
- Suggest giving ratings to functions, some are more important than others.
- Financial oversight at State level, checks and balances are needed.
- Compliance and Quality Improvement needs broad oversight– the total package should not be just at local level.
- Take out or reduce the role of state level administration whenever possible. There should be local management of services with state oversight.
- Balance oversight needed for small and large counties to ensure fairness.
- Funds are being redirected to counties and counties can used as the funds as directed at the local level.
- Clarification is needed regarding Realignment.
- County Boards of Supervisors need to focus on meeting the needs of clients.

Phone Participants

- The state should have a certain level of oversight of ALL functions.
- Stakeholders need more information about each of the functions in order to make an informed decision.
- It would be helpful for the state to provide a description of each function, as well as list which division/unit is currently responsible for each function.
- Compliance and Quality Improvement are two very different things and should not be grouped together. Quality Improvement should be listed in the same category with Access / Utilization.
- A category for Prevention should be included on the list of functions.
- A category for Special Populations (ex. Veterans) should be included on the list.
- Other categories that should be listed include: Office of Consumer and Family Affairs and Patients' Rights.
- The Office of Multi-Cultural Services must remain intact and could assume additional responsibilities, as well.

2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES
DATE: August 16, 2011 LOCATION: Fresno, CA

Break-Out Themes

- Stakeholder inclusion/involvement (consumers)
- More meaningful services at the local level
- Skill development for consumers
- More focused on recovery model
- Community focused – client driven – local
- Cross-training/education
- Collaboration and communication at state
- More jobs for consumers – more wellness centers
- Anti – stigma efforts
- Focus on cultural competence, co-occurring.
- TAY
- Reduce redundancies in oversight and reporting requirements
- Strengthen mental health boards and commissions
- Integrated mental health and substance use services – combine with ADP
- Military veterans involved with planning services
- Need descriptions of functions
- All functions need "some" level of state oversight
- Consumer Advisory Board with collaboration – DMH, DHCS, ADP, etc.
- Fidelity to MHSA
- Concern about fast track/timeline
- Ensure peer-to-peer supports and recovery model is not lost in transition

What do you believe are the challenges associated with the changes to mental health at the state level? How can these challenges be addressed?

- Are there Medi-Cal/medication changes? Benefits will be the same; placement and delivery may change
- It is important to have consumer stakeholders involved.
- Streamlining can be good, but we have to be careful. We might make it more complicated for consumers with top-down approach. No more barricades!
- Peer-to-peer/families/stakeholders need to have more powerful voice at the county level.
- The fiscal crisis at the State isn't over. There are existing structures that can deliver services (E.g. FQHCs) Federal health home; take advantage of existing structures.
- Mental illness is often a family trait, but family members may not have diagnosis. We need to change the stereotypes about mental illness. People still have value (workforce, etc.)
- There is a need for education campaign (PSAs) to combat stigma
- There is concern that [more] money will be taken away from MHSA. People don't see mental health as important. There needs to be a mental health education/anti-stigma campaign.

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

Phone Participants

- Preserving the integrity of prevention and early intervention. Caution needs to be taken so that these programs are not absorbed into direct services.
- Currently, there is a pool of consumers, family members and private providers who have a voice in the mental health system and in how services are provided. This pool of "expert advisors" must remain intact and the mechanism of utilizing these individuals must be re-established.
- Current efforts at contingency planning must continue.
- Creating an advisory board (approximately ten people) of representatives from government agencies, counties and providers would be helpful to ensure that mental health services continue to be provided at the appropriate level of government.
- Oversight needs to remain at the state level to ensure accountability and to keep the fidelity of the MHSA work that has already been done. The stakeholder voice must remain strong and be taken into account.
- Without oversight, counties will not be responsible to stakeholders.
- Consumers and family members must be heard from and not forgotten about during this process.
- Efficiency, not expediency.
- The fast-track of this process is a concern because it has excluded many individuals from participating. Things are moving too fast and many people have not had the opportunity to participate in these meetings.
- It is important not to lose the peer-to-peer support and the recovery model that has already been established.

Appendix VI

Notes from NAMI Conference Stakeholder Meeting August 18, 2011

CALIFORNIA DEPARTMENT OF
Mental Health

2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES
DATE: August 18, 2011 LOCATION: NAMI Conference, Sacramento, CA

Participants

85 Consumers/Family Members/Consumer Advocates
09 Providers
03 County Representatives
01 Other
98 Total Participants

DHCS Process and Summary Presentation Questions/Comments

- What is the budget for this transition? Why hire a new Deputy Director so late in the process? There is no budget. We hope to have savings, but that is not the identified goal There has been a desire expressed for focused leadership. We are working hard to get the "right" person for the job
- If the deadline for input is August 25th, how can we give input at the meetings after August 25th? August 22nd meeting to share report-then later share "Final" plan The door will not be closed, there will continue to be an option to provide input.
- With the budget cuts, funds have been taken from MHSA to fund Medi-Cal program. What about the lost of benefits (dental, vision, etc.)? Due to the budget crisis, there are only certain options: cut benefits, cut programs, etc. The benefits like preventive dental that were cut may be discussed as a part of the healthcare reform.
- Where are the county mental health boards represented? DHCS invited CMHDA to stakeholder meeting and had meeting with county mental health directors. DMH has been targeting local MH Boards.
- Re: AB102, with these changes how will services be affected or improved? You shouldn't see any negative impact on benefits or services as a result of the changes.
- Is AB106 connected to AB102? AB106 transfers the drug Medi-Cal program for substance abuse services. There are providers who serve clients with dual diagnosis.
- What impact will this have locally, especially for homeless individuals? The intent of the legislation is to improve coordination, hold counties accountable, and lead to improve local programs and services
- Is there any protection for the services that we have for mental health? We are hoping for a smooth transition with the opportunity for making it better. This shouldn't make things worse, it could make things better. There are also federal funding requirements
- What about mental health funding? CA has a transparent budget process. We couldn't do anything without the public knowing. In the past, the State General Fund has funded mental health. Starting 2013, the funding will be locally "owned" The "Non Federal Share" will be controlled by counties.
- Given organizational re-structuring, will there be an interest/opportunity in forming an advisory body to focus on cultural competence and reducing disparities? Cultural competence is very important to DHCS as well. DHCS has an Office of Minority Health (similar to DMH Office of Multicultural Services). We also have an advisory group. We understand how important it is for mental health. Submit your suggestions in writing We are interested in pursuing cultural competence.

Please note: Stakeholder questions appear in black font, DMH response indicated in red font

- Concerned about services for SMI within the criminal justice system. What will DHCS to coordinate with CDCR to ensure these services are provided? We are working with CDCR These services are very important For M/C eligible, we will provide services. For non-eligible-establish low-income health programs large array of services including basic MH services waivers and federal funds
- How will oversight and accountability be input into the local counties? DHCS is the single state agency for Medicaid, we are held responsible by the Federal Government. DHCS staff will review contracts, etc to ensure counties comply with Medi-cal programs requirements.
- Veterans services in CA tend to lack a sensitivity relative to mental health (they think people are faking to get money). Traumatic Brain Injury and Post Traumatic Stress Disorder are growing due to the wars. Is DHCS willing to educate the Dept. of Veteran Affairs (and other related agencies) about the stigma and reality of mental health

DMH Process and Summary Presentation Questions/Comments

- What are the contract funds for NAMI used for? Funds distributed to support NAMI.
- How does CiMH use their contract funds? They implement a statewide training plan, we have 16/17 projects that CiMH carries out.
- Why was this process moved forward so quickly? Legislation was passed (AB100/102/106) and we have to meet deadlines for Legislature and Governor's budget considerations.
- Systems are required to provide services regardless of funding streams. How can you formulate something that will provide the full array of services (prevention, wraparound, etc.) for all age groups? The Federal Medicare Waiver and health care reform →localization of services to the county level.
- How will re-organization: ensure inform data collection; ensure input/ inclusion of clients and family members:...(etc.)
- What about State Hospitals? Is there a Dept. of State Hospitals or fold into community MH? Where is the analysis to support the decision made re: State Hospitals? NAMI CA is asking for experts to be brought to the table we are asking to see the analysis – what consideration are being made. Nobody is talking about it, we need to fix that, it's not ok. DMH is beginning this discussion. 93% of State Hospital patients have ties to criminal justice system. What about the remaining 7%?
- We need to reduce forensic hospitalizations and make room for civil commitments. Giving hospitals to CDCR criminalizes mental illness.
- We need to have more of a focus on prevention at the front end, services to reduce recidivism, etc.
- DMH responsibilities are being reduced to community mental health and many of those responsibilities are shifting to county mental health. How will DMH accomplish remaining functions with so few staff? Reduction of staff positions is not equivalent to a reduction in commitment. DMH is working with counties to determine their needs. Medi-Cal functions are going to DHCS. We want this transition to succeed!

What opportunities do you see as a result of the transition at the state level?

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES
DATE: August 18, 2011 LOCATION: NAMI Conference, Sacramento, CA

- I heard there was a transfer of 120 positions. How many positions will stay at DMH? 121 - IT, Community Services, Auditors. 300 positions at Headquarters.
- How many positions will be at the new department? We don't know, we will get that information to Jessica Cruz.
- Recommend that these meetings are recorded to help participants prepare for these meetings. Flip chart notes will be posted and will include stakeholder comments.
- We have to fix this problem (Forensics/criminalization esp. for African Americans) council of mentally ill offenders – no one from DMH comes to those meetings. We need a cultural competence approaching inner-cities. Let's reach out to African American churches in communities. Faith based approaches need to be included.
- Regarding the AB102 Medi-Cal transfer, I am concerned about medication, care homes, etc.
- Not enough information was provided prior to this meeting, could not get the word out statewide. There are survivors, clients and family members that have not been heard. We have been left-out because the process has been fast tracked. I hope there will be more opportunities for client survivors to provide input. The Network has not decided which option to support, but there are challenges with all options – more information is needed for clients to provide educated input.
- I am concerned about future loss of MHSA funds and supplantation.
- The single most important factor for client participation, that has not been available, is funding for travel.
- Without State oversight, I am extremely concerned about local control of critical functions.
- I am also concerned about the criminal justice system. The Network has positions on this issue and would like to add to that discussion.
- Dual-diagnosis → opportunities for integrated treatment options
- Excited that funding is going to counties; local oversight bodies can be created.
- Is there an opportunity for more positions, is the legislature preventing this from happening? We need to know what many positions to know if DMH (or new Dept.) is a viable option.
- We don't know which boxes to choose. Get more input from clients/family members about what we need.
- Transportation is important.
- What about county based meetings?
- What about consumers? They need to have a voice. DMH is working with counties to get the word out. Also, work with NAMI, UACF, CA Network for MH Clients. We will post comments/position papers on the DMH website.

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

Appendix VII

Notes from Los Angeles County Regional Stakeholder Meeting August 25, 2011

CALIFORNIA DEPARTMENT OF Mental Health

2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES
DATE: August 25, 2011 LOCATION: Los Angeles, CA

Participants

115 Consumers/Family Members/Consumer Advocates
93 Providers
33 County Representatives
06 Other
13 Phone Participants
260 Total Participants

Pre-Meeting Education Session- Questions/Comments

- Is there going to be an explanation of the impact of moving these functions to a particular entity? What are the potential outcomes?
- What are the options for consideration? There are many options due to the stakeholder process: 1) DHCS could create a Division of Mental Health; 2) DMH could continue to operate with a Community Services Division (status quo); 3) What do you think should happen?
- Is this process about state or local functions? This process will help us to determine which functions should stay at the state level and who should "house" them and which functions should shift to the local level.
- Does the local stakeholder process input get reviewed at the state level, for the purposes of this process? Marv Southard holds stakeholder meetings in Los Angeles, some of that information gathered might be useful to you. That is a great suggestion to make during the break-out sessions later.
- Will DMH continue to be under the CA Health and Human Services Agency? If the programs/functions move, will the money follow? Yes, the functions will stay under CHHS. The money will [likely] follow the programs.
- What will be the role of the MHSOAC and/or CalMHSA? AB100 clarifies some specific functions of the MHSOAC. This stakeholder process (especially in break-outs) will give participants and opportunity to weigh in on the MHSOAC and CalMHSA

Background and Context Questions/Comments

- What are the possible options for these functions?
    1. Option One: Move all functions to DHCS
    2. Option Two: Create a new behavioral health department with both alcohol and drug services and mental health services
    3. Option Three: Move Medi-Cal functions to DHCS and align remaining functions with various appropriate state level agencies
    4. Option Four: Retian a stand-alone Department of Mental Health
- How will the creation of a new department of behavioral health un-do or align with the Governor's direction regarding the elimination of DMH and ADP? AB100, AB102, and AB106 speak only to the transfer of Medi-Cal services.

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

- Is it true that DHCS does not want all of the "qualitative functions"? If so, is transfer of remaining functions to DHCS even an option? They are trying to figure out what they can take on. The new Director, Toby Douglas, is working through these issues.
- With the transition, are there any garantees, regarding MHSA money NOT being used for other types of services instead of mental health? There is a state level group discussing this issue.
- We don't know enough about the options. There should be another process to educate consumers and get feedback.

Based upon today's presentation, what are the changes in mental health at the state level that stand out for you?

- What is the jurisdiction of the Department of Corrections [as it relates to the state hospitals]? DMH will, at some level, become the Department of State Hospitals. Can there be a collective approach to run the hospitals? This question is being considered. NAMI didn't like this idea about a connection between the Receiver, Hospitals and CDCR. But, 93% of the Hospital population is forensic commitments; only 7% is civil commitments.
- There is a possibility for fragmentation with the transfer to DHCS. There are important functions that need to NOT be glossed over (e.g., licensing and certification and Office of Consumer Affairs). Let's think about these more in the break-outs.
- The budget resources being used by the Governor and taken from consumers is wrong.
- Consumers need to continue to be a part of the discussion/process. This can't be the only opportunity for input.
- Regarding the 19 positions, there doesn't seem to be a focus on cultural competence. Especially, the Office of Multicultural Services. What is the plan? Will there be a new Chief hired to replace Rachel Guerrero? This is a big concern all over the State. The OMS still exists: Kimberly Knifong and Marina Augusto. The suggestion to hire a Chief/leader will be in the Summary Report to the Legislature.
- The idea of moving children's funding [AB3632] to Education is a horrible idea. The teachers don't have the psychiatric training. That money was already moved to CDE.
- How does health care reform (2014) align with this process? DHCS is the single state agency for health care reform. The options (1-4) will have a plan for health care reform built in to them.
- The message about Prop 63 MHSA, Prevention and Innovation, needs to be brought back to Sacramento. These are new kinds of services, not within the medical model.
- Please make sure to include deaf culture in additional to racial/ethnic cultural competence.
- What is the role of the local Mental Health Boards/Commissions? We have had good communication with Kerry Martin and local county mental health directors to get feedback/involvement and strengthen partnership with the local Boards and Commissions.

2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES
DATE: August 25, 2011 LOCATION: Los Angeles, CA

What opportunities do you see as a result of the transition at the state level?

Consumers/Family Members/Consumer Advocates (LPS Conservators)

- Opportunities for the Administration to understand what consumers are feeling; their wellbeing needs to be considered.
- This is an opportunity to bring logic to an illogical system. We can reorganize services to fit needs of the people.
- Don't make it more complicated→focus on well being
- "Local Control" is disempowering for people. Where is the accountability? We need to create an enforcement system.
- We need to focus on client councils, wellness and recovery; this is already being done in other organizations.
- How do we get the services back to the people? Income?
- Give people skills and find them appropriate employment.
- More direct consumer input.
- Create uniformity across sites for services.
- Embrace the idea of consumers and leadership to work together. We need to bring consumers and family members into a leadership role across all services systems. The same goes for LPS Conservators.
- Reduce bureaucracy and create clearer lines of community.
- "Out w/ the old, in w/the new"
    - Emphasize innovation, go for holistic approach.
    - Streamline of organization → take away the middleman.
    - Accountability
    - Commissions and Boards need best practices.
    - 5604 mandate
- We only need local boards and counties, board of supervisors needs to be responsible.
- MHSOAC oversees MHSA
- This is an opportunity to eliminate the state planning council.
- Measure outcomes over time
- Integrate mental health and alcohol and drug programs. Rethink long term recovery strategies under mental health. Emphasize wellness and recovery approach within the context of alcohol and drug services.
- As a patient advocate at the state level, if we choose to keep AOD and MH services separate, IF there is a Deputy Director for both, it is best to keep it the separate the way that it is. We need expertise for these populations.
- I feel that 70% of consumers have alcohol and drug issues, then they should be connected more (co-occurring disorders).
- Will DMH go away? How will this work? What is the ultimate reason for the integration? Why is this happening?
- Is this part of Obama's federal health care reform (ACA)?
- In the past, things were run poorly, but now things are better for consumers and family members. I am concerned that this will change for us.
- Are local providers under the authority of mental health boards?
- What about small cities (or counties)? Will there be a difference between those that have more resources and those that have less resources? How do we balance that issue? My

nephew had to come to a larger county to get more services. Counties need sufficient resources for our families and consumers.
- Can the funding for a client/consumer be transferred to where they need to be? The oversight at the local level can't support this well.
- Are other states doing this (move things locally)?
- What will happen with veterans with PTSD? Will they continue to get services?
- We need to have a voice for families, parents, caregivers, and clients at the state and/or county level.
- This is a large county (land/geographically) but here are no transportation services or public transit. In Santa Clarita, the programs are too spread out.
- We need to build integrated systems for alcohol & drug services, mental health, and physical health.
- This is an opportunity for local control and to address disparities but we need safeguards to ensure community participation. We need to avoid the medical model.
- Provide stipends for community leaders to work on prevention.
- We need opportunities for youth involvement at the state and local level.
- As a parent partner, I have a huge concern that not all opportunities are positive; there are also opportunities for discrimination for unserved communities. Access to resources is scarce.
- Client operated services can be increased and improved.
- New employment opportunities for client/family members at the state level.
- New funding for programs in the inner cities.
- The reason that the Governor is making these changes is to reduce state funding, realignment is good for counties.

County Representatives and Providers
- Consumers in the County didn't get information on MHSA-television information about the MHSA-consumers need information on how to work with mental health issues.
- Increased access
- Advocacy groups work with consultants so consumer voices can be heard
- I have concerns about services for deaf and hard of hearing children
- Deaf and hard of hearing individuals need to be counted as a part of the under-respresented/unserved populations.
- This is a good opportunity to meld co-occurring disorders together, keep things from slipping through the cracks.
- Funding for adult day health care centers is being eliminated, what DMH will do to continue services? There are 18,000 is Los Angeles.
- School districts are the largest mental health providers. They are the first line, but the most underfunded.
- To facilitate improvement of mental health services, make documentation/paperwork more uniform, easier to understand, a "boilerplate" to provide services. Design a standardized process from county to county.

- As we try to reduce disparities in access to services for local communities (under-represented ethnic communities) we need to increase cultural competency.
- Opportunity for professionals and service extenders to work together.
- Opportunity for alcohol and drug providers and mental health services to work together.
- I am concerned that AOD will be subsumed under mental health issues.
- I don't believe there is sufficient training for consumers in MHSA.
- Under MHSA, there is an opportunity for outreach, placement, and engagement in shelters. We need more people to work in shelters, now up to 600 people per night.

Phone Participants

- If stakeholders truly get a say and their comments are genuinely incorporated into the plan, there is potential for many opportunities.
- More funding at the local level will be beneficial for consumers because more resources will be available at the local level.
- There is an opportunity for standardization (statewide) of how services are provided at the county level.
- This is an opportunity to establish a baseline level of services and accountability.
- Current rules and regulations surrounding MHSA funds are too strict and prohibitive. Many people are not able to access all the services they need because of these rules. This is an opportunity to remove many of these barriers and be able to provide services that are tailored to certain populations.
- Currently, there is a disparity between the way in which Medi-Cal services and community mental health services are provided and funded. This is an opportunity to balance out this disparity.

Which entity should assume responsibility for the functions/programs listed? What functions/programs are missing from the list?

Consumers/Family Members/Community Advocates

- Consolidation of the organization
- I want CalMHSA to go and the function of financial oversight to go to the locals.
- If funding goes to CalMHSA, will the people still get the services?
- [16 group members wanted CalMHSA to have financial oversight]
- What's the real reason the Administration wants to move this to the local authority?
- When Prop 63 passed, we got a community process. That is going great. We don't want this to change at all.
- Housing needs to stay local. We know what the need is. In Sacramento, you don't know our needs. It is best to go from local to state (resources to reporting).
- My son receives services through LA County DMH, we like it there. All of the functions should go there.

- What does the CMHPC do? [14 people voted for compliance/quality improvement functions to go to the CMHPC]
- My son is sick and the police criminalize him. They don't listen to him or understand his illness. He's on probation right now; doesn't make any money. So the family suffers the burden. This should not happen in America. They are not treated with access to services, his is sick and needs supports. He asks local agencies for help, not to criminalize him, but no one helps. They want to keep him institutionalized for 1 year. It is expensive to institutionalize people, this transition will help keep them out of that level of services.
- In the Cambodian community, mental health is a disgrace. They want stigma to be taken care of. It is hard to get help.
- [25 votes for stigma to go to CalMHSA]
- EMHI: I have a son getting great services.
- [26 votes to keep EMHI at the state DMH]
- Technical assistance needs state oversight; the ability to do this is at higher levels, like SAMHSA.
- As much local control as possible; limit the state role. The county makes the best decisions for counties.
- Does the amount of positions limit the focus on Prevention and Early Intervention? It can't all be Medi-Cal services, focus on prevention.
- NAMI CA opposes the idea of everything being put under DHCS. CCMH came up with 22 non Medi-Cal functions.
- Mental health needs a home: the Department of Mental Health and Alcohol & Drug Services.
- I concur with NAMI CA, mental health needs a home.
- Other departments may lack the mental health expertise to provide proper services.
- In a climate of reduced funding/ is there a danger of a loss of commitment to closing cultural gaps of disparities?
- What about the aging population?
- The process is moving too fast to permit adequate input, especially given the size of LA.
- The MHSA was supposed to be transformative, voluntary services. With a lack of state level oversight, who will ensure that services will be voluntary?
- Transportation is an issue that needs to be addressed at the local level.
- If funding is transferred to counties, there needs to be a strategic plan to guarantee funds are used for mental health services, not other types of services.

County Representatives and Providers

- The overall mental health budget should be at the state level, not just reversion.
- Before MHSA, mental health services weren't garunteed. No fragmentation of services, all programs should be like MHSA programs. That would be a dream come true.
- Don't make mental health services a "step child".
- Always emphasize cultural competence.
- The mental health community is very fragmented. We need a voice at the state level to organize us as a group.
- People are concerned that they don't have enough detailed information to make "arbitrary" decisions where these programs should go.
- Why are we reinventing the wheel? Why are we allowing the Governor to fragment these services?
- If the functions move to a new organization, will sufficient funds/resources go with the functions?
- We know how many positions DMH has, do we know how many positions are in the other departments?
- If we shift functions to different departments, there won't be sufficient training for new departments can do the work.

Phone Participants

- The state should not decide how counties are spending funds; however, they should retain oversight to ensure that funds are being spent appropriately.
- Counties (local) should assume responsibility of Suicide Prevention, Stigma and Discrimination and Multicultural Services because they are more equipped to handle these functions. The local level has a better grasp of what is happening in the community and where the needs are greatest in these programs.
- The state should retain responsibility of Financial Oversight, Issue Resolution, Technical Assistance, Access and Utilization, Program Evaluation and Compliance & Quality Improvement.

Break-Out Themes

- Maintain focus on prevention and early intervention
- Transportation issues prevent access to services locally.
- Voice for consumers, family members, caregivers, parent partners, transition age youth, and older adults
- Local control with safeguards
- Increased employment opportunities for consumers and increased client operated services and programs
- Cultural competence- reduced disparities/increased access to services
- Funding to counties faster! Increase in the number and quality of services for communities (unserved, underserved, inner cities, etc.)

- Local control of functions, the transition needs to be strategic

What do you believe are the challenges associated with the changes to mental health at the state level? How can these challenges be addressed?

- As a parent, I want to ensure that parents continue to be a part of the state level policy decisions- the voices of parents need to be included.
- There should be an independent review of the health services- a lot of the same people are in charge- people are suffering because people want to do things the "old way".
- There is a lack of services for the deaf and hard of hearing statewide
- When the decisions are finalized there needs to be a strong foundation to implement those decisions.
- UACF needs to be included in this process; they have more expertise regarding children's issues and parents/families.
- MHSA is a wonderful opportunity to change the "old way", but there is not as much inclusion of family members as there should be. Family members need to be included in the process. There need to be more opportunities for supportive services for families so that they can get help before there is a crisis. We need to ask family member what they need for support; we need to be more flexible.
- Stigma and discrimination is a huge problem and needs to be addressed.
- Some of the questions posed today seem more like window dressing. It's an impossible situation. What can DMH do with only 19 staff? I can't speak to the placement of functions. Use the guiding principles (below) and do your best to make the decisions.
    1. Retain the integrity of MHSA. The MHSA is the best thing that has happened to mental health.
    2. Mental health needs to be elevated in whatever system is decided upon.
    3. Avoid fragmentation and further complication (silo-ing) of the system
    4. Continue to support consumers and family members
    5. Continue to support multicultural services [the Office of Multicultural Services at DMH] and the California Reducing Disparities Project. Reducing disparities is a national issue and needs a state focus.
- Maintain the voluntary nature of services- no forced commitments (5150's). There needs to be state level oversight to ensure that MHSA funded programs are voluntary.
- The consumer movement is critical. We deserve human rights and civil rights. That's what we are fighting for in the consumer movement.
- I agree with the danger of fragmentation. We need unifying principles. If DMH and ADP are folded into DHCS, they should change their name to be more inclusive and unifying.
- Unification of services
- Maintain the focus on the recovery model
- CA has the largest Asian/Pacific Islander population; we cannot lose sight of services for this population.
- Clients and family members need to have input into county plans. We [counties] don't know what they are talking about until they talk to clients.

Phone Participants

- There needs to be a non-biased, non-political group of consumers and family members to provide state level policy input and oversight.
- Oversight will disappear. The oversight needs to continue on a continual basis – don't wait for something bad to happen first.
- No single person or entity should have complete control.
- There should be a blend of local and state authority.
- There needs to be equity in how counties get money. Currently, there is not equity and many counties, especially smaller, rural counties, are not getting enough funding.
- There is a disparity among veterans and children (in the services they receive) which needs to be addressed.

Appendix VIII

Notes from San Bernardino County Regional Stakeholder Meeting August 26, 2011

CALIFORNIA DEPARTMENT OF
Mental Health

2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES
DATE: August 26, 2011 LOCATION: San Bernardino, CA

Participants

Consumers/Family Members/Consumer Advocates
Providers
County Representatives
Other
Phone Participants
Total Participants

Pre-Meeting Education Session- Questions/Comments

- Regarding WET, we are talking about preparing people to go into MH system. Correct? What about pre-employment training for consumers? Working well Together is a contract program that does some employment preparation for consumers This is not however, a current function of the State DMH.
- Caregiver Resource Centers can go to the Dept. of Aging
- What will happen after the stakeholder process? Who will be making the final decisions about where the functions will go? DMH will prepare a summary of stakeholder input and forward it to Legislature
- ADP and DMH do not translate or cross-over, there is a different language. We don't want to be under an agency that requires that criteria are met before services are offered. It is disheartening that so much has been taken away. "The fox isn't guarding the hen house."
- Applaud the county for having AOD under Behavioral Health, are you thinking about health services as you move closer to health care reform in 2014.

Background and Context Questions/Comments

- Do the local entities have the resources to cover the functions? The budget discussions have not happened about shifting from State to Local. If shifting to another State agency, funding will follow.
- How will all of this help w/ housing, businesses, and the economy.
- Executive leadership is important. The designated staff does not include Executive leadership. Where are these position. The current structure is that a CEA level (Exec manager) and other managers report to the CEA
- The mental health leadership needs to have subject matter expertise. The Director of DHCS is committed to ensuring that the leadership for mental health / Alcohol and drug Programs is a subject matter expert (SME) DMH staff w. SME will follow Medi-Cal functions to DHCS. The 19 positions are all SME's
- What is DMH currently thinking?

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

There are four options:
1)Move all functions to DHCS
2)Create a joint DMH/ADP agency
3)Stand alone mental health dept.
4)Move functions to appropriate other state or local entities

- Do we still have a chance to influence the decision-making? Yes, these meetings will make up the DMH summary report that will be forwarded to legislature for consideration We will share info on September 16th through a webinar on-going stakeholder meeting monthly through July
- What about services for homeless? If the state should be doing more let us know in the break-outs
- Are we only talking about the 19 positions and functions? The Medi-Cal staff/functions are going to DHCS. If you don't think 19 staff is enough, let us know that too.

Based upon today's presentation, what are the changes in mental health at the state level that stand out for you?

WHAT STANDS OUT?

- Freeze on volunteer badges? When is that coming off?
- It is better to have one system of care. Having the functions/funding broken up could cause more problems (e.g. reporting to multiple entities)
- The State needs to provide a leadership and oversight role. There should be some strong commitment to leadership and oversight and standardization. Some counties do not roll out services in a consistent manner.
- System of Care
- Concerned about fragmenting the system of care for older Adults
  Services, reporting, one system of care
- What about services (e.g. club houses)
- Organizing around funding source fragments and creates silos. We need to think 5-10-15 years. Healthcare reform. I would like to see a Dept. of Health Systems w/ DHCS, ADP, DMH "not merging" but coming together as systems
  Blowup the boxes and redesign the boxes w/ funding to cut across horizontally
  Up & down, left & right

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES
DATE: August 26, 2011 LOCATION: San Bernardino, CA

What opportunities do you see as a result of the transition at the state level?

Consumers/Family Members/Consumer Advocates
Information-Think from the <3 – Consumer Family

1) Opp to reduce the hospililication ratc by using PEER RUN Respite Carters.
2) Expand the concept of wellness and recovery across the system of care. Wellness and recovery can become the baseline for all services. Movement Not Lose Its Movement (Wellness and Recovery's Higher Standard be the higher minimum high raise the standard.
3) More people available who can provide info on service that are available.
4) More navigators on the ground streets, community.
5) System of referral with people with HIV.
6) Opp to demonstrate commitment to CA ethic, ..., EI, blind, hardoftlearing Demon, creating and sustaining a community prevention LGBTQ. Veterans mere money will be found to those specific
7) Credit better lines of communication. On Suggestion that have been made
8) More info on Medical and Dental, Vision. (Statewide budget cuts)
9) New prog addressing dule problems were resource can be use across both conditions IE Meds
10) To improve access by reducing criteria for eligibility to services.
11) Better more services that will help consumer find appropriate help.
12) Eliminate tax brake from wealthy cooperation's and people.
13) Opp to make it better for our children 10-15 years from now
14) Opp to develop better and more prevention programs.
15) Opp for stakeholders to be at final decision making table
16) Enforcement of the diagnostic assessment protocol w/ and follow up, to ensure the person has a meaningful life.

With you we make a difference! –FYRT of SD County

WE MUST BE AT THE FINAL DECISION MEETINGS –Nothing About Us Without US. That Means ALL of us.

County Representatives

COUNTY BREAKOUT
What opportunities do you see as a result of these changes?

- Oppt. To develop one cohesive system – basic framework, principle are the same need to combine into one health system

- Educational – get more insight into these other agencies. Will help us move to a more cohesive system and opens up communication
- Work more effectively and efficiently
- Helps for svcs to be at the county level because we are closer to the people receiving svcs. We know our demographic and can tailor services
- The responsibilities have to come from resources.
- Concerned about quality of svcs w/no state level oversight. SB County is the gold stnd =) but what about other counties that don't have enough staff?
- Needs to be an awareness of checks and balances. Different practioners have different need and perspectives. Need a clear understanding priorities and expectations.
- We need a strategic plan to move to one system goals and objectives
- We need to make sure our {beh health} needs are met
- There needs to be an education component to help people understanding what they can expect
- Educating the system-people providing services
- There is an assumption that counties have the expertise that is 95% true, but that is not necessarily true about housing. It's a whole different field, level of expertise, etc. County mental health/Beh health providers are not housing experts. Serious thought needs to be given to this if these responsibilities are shifted to the local level.
- Housing = for profit venture mental health is about svcs and supports those two systems are not compatible
- What are the mission and goals of the {proposed} health system?

FUNCTION

- There are some things that the state has more expertise – housing is one of them. Be cautious about transferring this function locally
- Infuse local level w/experts
- Quality Improvement and Evaluation – the best "policing" is done in-house. We have our own cultures. Improving the system of care should happen at the local level.
- Looking at funding, we could put fed at risk if we don't have a statewide standard measurement system there has to be consistency of care.
- We need a consistent forward movement. We need to include programs people in evaluation.
- Evaluation/QI – data collection and reporting systems that function should be managed in one place.
- Make data more accessible ADP does a great breakdown for every county. They do the work for me.
- When it comes to data & QI it can be difficult to do that locally b/c we are too close to the action or we don't see the flaws or cover-ups
- It should be a collaborative process that includes state and local
- Inspector general model a third party at state or local level can provide cohesiveness
- We want support from the state but we also want local control of QI/Program Eval.

- State can provide education and technical assistance.
- Federal grant programs (PATH, SAMHSA, etc.) – I don't see how these can be managed at the local level.
- It's about what is going to keep the money flowing
- The process needs to be integrated and statewide.
- What's wrong w/ what DMH has been providing?
- EMHI-State oversight and administration to prevent misuse of MH funds

Providers

Provider Opportunity
- The more funct. can be integrated with something in larger

-merge the function under 1 umberlla/under 1 roof (fluid)

→Physical Health
→Mental Helath
→Substance Abuse
"All one equal footing"
DHCS – Suicide Prevention
Where talking "Super Store"
w/Strong leadership

Please note: Stakeholder questions appear in black font, DMH response indicated in red font

Phone Participants

Which entity should assume responsibility for the functions/programs listed? What functions/programs are missing from the list?

County Representatives
COUNY GROUP 2
Riverside, San Diego and San Bern

- Caregiver Resource Center CRC→ CDA THIe3E: CRC should be moved to CDA to avoid duplication of svs→ just have one system. CDA already has funding mechanisms
- What happens to the unfunded?
- Keep together medical, MHSA etc
- Merge ADP/DMH to eliminate fragment, simplify → one audit, one system (not compartments within 1 system)
  Co-Occ Dis.

WET

- Go to CalMHSA→not all WET programs receive "statewideness" currently no reporting reg regarding state work/stipends.
- Retain SP/SMHI/Stigma under CalMHSA.
  System Issues:
- Merging Medicaid may lose MH parity
  → May move away from recovery TV a medical model
- Merging AOD/DMH→ should emphasize the MH guidelines, leadership should know about recovery etc
  →Educate the rest of DHCS
- MH usually gets 'swallowed up' in general medical system, merging with DHCS → we need to make sure they are fully integrated into the systems. Don't let MH get lost in the system. There is already stigma of MI in the system
- There must be built in MH parity in svs.

- Billing for MH/AOD services →make it easier for MH + AOD + Medical services

TECHNICAL ASSISTANCE

- Answering the phone→ know the answer!
- Expertise
- CiMH has done a good job with training → keep their contract no matter where their contracts land (MHSOAC?)
- OAC has been helpful for MHSA projects

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

HOUSING
- Local→Takeout middlemen HUD is only partner

DISATER
- Local→ county deals directly w/Red Cross/FEMA
- Multi-county disaster may require state assistance

Prog Eval + Compliance/Qual imp + Financial
- ➔ Should be merged. go to DHCS. Oversight
- ➔ 1 audit for all by people with MH expertise.

ISSUE RESOLUTION
- Goto DHCS. since MH+AOD Medical are going to them.
- Go to OAC→provide oversight to DHCS
- Go to DMH/ADP

WET advocacy (not operations) should go to Planning council
- Worried about fragmentation if functions go to multiple agencies.

Data collection
- Only report/collect if the data is used
- Data should be protocaled b/w each county (data dictionary etc) (standardize the data)
- Go to OAC for outcomes reporting
- Above all, data should be centralized and access it at one place (don t send it out individually to each agency that request it) (pan-agency data warehouse)

NON-REVOKABLE PAROLEES
→go to probation office
LICENSING/CERTIFICATION
→licensing/cerl requirements for room + board facilities.
Co-occurring disorders
→local but more DHCS
PATH
→CalMHSA
Concern: If there will be no DMH will its remaining functions get lost w/in the larger medical system? Where's the leadership?
Great structure MDHCS that gives MH + AOD aout w/in the system
Office of Multicultural services
- ➔ Place in DHCS, put keep it MH specific
- IMD: →put in DHCS, under MH unit

Providers

Provider Cynthia
What I didn't hear - don't know what the state is hearing – all notes being posted on DMH website – there will also be report (DMH Website – what's new DHCS)

-Will it be the will of the people
-Or legislature
CB –response
Transit Plan – will be sent to leg. final decision will be made there DMH 9 mil total
-Chunk (Medical functions) to DHCS
-Sounds like we're funct. w/functions left-19-listed more extensive

CB
Clarifying what DMH resp. for
Trying to reconcile – w/list (doesn't match)
-we're talk about 2 mil (doesn't seem like a big deadl)worth of functions??? Is that they task at hand for 19 positions = 2mil
What is the task at hand
-Approval of plans for Housing (DMH still responsible for this?)

CB
Focus on the funtions

The money tied to function would transfer
?which organization will manage it better
-Where do you all think
Disaduant. So Cal – No Cal – cont. to make decisions
-decentralized
-under equity
They go where there is need and resources
Disadvantaged getting care mix match and lack of alignment
-more equitable distrib.
Improved
Regulation

Where would the alignment be?
-proportion resources
Dept of Justice into MHS there's a huge gap – many child and adults are sent home w/med – agencies have to scurry around to get this in format – "marry the services"
Justice and mental Health the import of information sharing

-DOJ should be req'd to work to MH
-Health Care should be included also
-the importance of Elect Health Rec
-continuity of Care/Services –
Need to put "client" first
Do not "re-create the wheel"

Where as providers you thing function should go (integration of functions)
-do not cont. to biforate (funding services)
MH AOD etc.
Do not become step children in Public health System
"Health and Behavioral Health Systems" (New Department)

Physical and Behavioral Health System

Challenge – is still the "stigma"

Provide broad education and understanding.

Best place to house education program – DHCS (will this limit local level (funding))
Stigma Reduction

DHCS – will have Medi-Cal if you start splintering functions you will not have a cohesiveness

OAC-putting evaluation piece together

If the money goes local who's going to have oversight of co-Board of Supervisors, etc.
Who response/oversees Board of Supervisors – response nobody

If function go to different department = "fragmentation" splintering of functions – move administrative expenses.

-Quality outcomes would go under state (DHCS)
Recc State could contract w/
What about CalMHSA??

Challenge – if you don't know what folks do-hard to determine
We should be talking about efficiencies

??SAMHSABG

- We want MH to have equal "footing" with physical health
- 1 Shop Stop
  - Physical health
  - AOD services

You can't bill 4 more than 1 service per day

- Mental Health

- Have we arrived at a consensus
- Veterans-DMH partners w/ CA
  Vets – not all co's have large military pop-resources should go to both local and at state DMH

  Dr. David Patting (article)
  (Support what we're saying) doc

- Workforce education (load programs; stipends) (DHCS-contract out) when appropriate
- Destigmatizing starts with in the schools. → graducate schools of social work →nursing →physician (Calswift?) or →Psychairtrist

Getting rid of the silos "blowingup the boxes"

Phone Participants

Break-Out Themes

BREAK OUT THEMES

- One cohesive, comprehensive system of care w/health mental health and alcohol and drug programs unified goals/principles
- Educational component and strategic plan to make it clear
- Local Autonomy – recognizing uniqueness of 58 counties
- Responsibilities AND Resources
- Quality of Care: Focus
- Meet the needs of consumers
- Reduce fragmentation and increase efficiency
- Mental health and alcohol and drug programs need clout, cannot lose focus on Recovery by falling back to medical model
- Standardized data collection and reporting
- Continuity of services and oversight
- Opportunity to reduce hospitalization rates
- Expand wellness and recovery across the system of care
- Make time to educate people before we ask for input, we need more navigators
- Improved referral system
- Commitment to cultural competence – racial/ethnic communities
- Veterans

- Need to know how much money/Resources is available with the functions
- Whole person approach
- Look at eligibility requirements
- Eliminate tax breaks for corporations
- Increased opportunity for children
- Include Stakeholders at FINAL Decision-making table
- Strong leadership
- Outcome based incentives

What do you believe are the challenges associated with the changes to mental health at the state level? How can these challenges be addressed?

WHAT ARE THE CHALLENGES?

- We have a lot of people into power and control. [Resources] are spread out. What can we do to improve collaboration and sharing? San Bernardino is a model =)
- It's not about saving jobs - it's about services.
- Don't move ahead too quickly. Push for mental health leadership. Do what is right because it's the right thing. Don't be intimated due to lack of resources. Be courageous!
- Our biggest challenge is going to be our own fears of change. The people needing services (not jobs) is the #1 priority
- Inclusion and collaboration promote organizational health
- Consumers and providers need to continue to be at the table. Let providers share what they think w/o fear of retribution oversight and accountability
- Reporting transparency

Phone Participants

Please note: Stakeholder questions appear in black font, DMH response indicated in red font

Appendix IX

Notes from San Luis Obispo County Regional Stakeholder Meeting September 1, 2011

CALIFORNIA DEPARTMENT OF
Mental Health

2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES
DATE: September 1, 2011 LOCATION: San Luis Obispo, CA

Participants

09 Consumers/Family Members/Consumer Advocates
24 Providers
32 County Representatives
02 Other
05 Phone Participants
72 Total Participants

Pre-Meeting Education Session- Questions/Comments

- Did issue resolution get moved to Department of Health Care Services? The Medi-Cal ombudsman will move to Department of Health Care Services, but issue resolution [for Mental Health Services Act and others] will be at Department of Mental Health until the stakeholder input is reviewed and additional changes are made as a result. Today's meeting gives you a change for input.
- $8 million does not seem like enough money to serve all of the clients with need in California.
- Are the State Hospitals going to be a part of the discussion today? The main focus of this stakeholder meeting is about non Medi-Cal/non hospital functions. To provide input/comments regarding state hospitals. Send comments in writing and/or talk to Kathy Gaitlee.
- I am very concerned about the talk to combine the state hospitals with California Department of Correction Rehabilitation. Will there be opportunities for stakeholders to provide input about that option [for State Hospitals]? I don't think that's a good idea.

Background and Context Questions/Comments

- Are there any functions related to Institution for Mental Diseases? Those functions will remain at Department of Mental Health until July 2012, after that oversight of Institution for Mental Disease's will be moved-don't yet know where.
- Is the $8.8 million to fund programs or just for Administration (Budget Detail Sheet)? This funding is for staff at Department of Mental Health and other state departments and the funding also includes contract funds.
- There should be 5% for State Administration. AB100 Elimination of State approval of county Mental Health Services Act programs reduced this amount to 3.5% - we may not be using all of the 3.5%. If we need more stuff, you should tell us that today.
- The contract funds at the State are used for what? Not services? The contracts fund consumer organizations, reducing disparities, efforts, statewide training, etc.
- Are those the only contracts at Department of Mental Health? Are there others, like External Quality Review Organization? The External Quality Review Organization

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

contract will no longer be monitored by Department of Mental Health, that contract will be moved to Department of Health Care Services. There are other contracts that are not listed-Workforce, Education and Training contracts, Co-Op, etc.

- Is there a "wish list" for when the economy recovers?
- After all info is gathered, how will you weigh responses (small rural county input is large urban counties)? The report will be a summary of the input → common themes, etc. Multicultural Services is a big concern all over the State.
- Prioritize those recommendations that are most consistent with Mental Health Services Act guiding principles (consumer input and cultural competence). Another consistent question has been about leadership - Mental Health leadership at State and specifically at Department of Health Care Services. Department of Health Care Services Report→ senate confirmed deputy director responsible for Medi-Cal Mental Health.
- When you separate all the funding streams (Realignment, 3632, Short Doyle, etc.) it becomes easier for legislators to take funding away. It also complicates services from blended funding sources. This is a common response.
- Where is Conrep money going?
- We need a global focus, Mental Health services in Africa have been ignored in the U.S.

Based upon today's presentation, what are the changes in mental health at the state level that stand out for you?

- Concerned about mental health moving under Health. Concerned about funding being taken from mental health services. This move to Department of Health Care Services is about moving staff resources; it should not affect the level of funding services.
- There is move funding for mental health services than ever before.
- Have there been cuts to other state organizations, such as Mental Health Services Oversight and Accountability Commission? Those other state agencies Planning Council and Mental Health Services Oversight and Accountability Commission were not affected this is just about the impact on Department of Mental Health.

What opportunities do you see as a result of the transition at the state level?

County Representatives

- All to Department of Health Care Services
- Combine Non-mental health to Department of Health Care Services
- Create a bigger Department of Mental Health
- Oversight of funds

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

- No benefit to stay at the state level
- Keep local
- If services are to be transferal to the local level. Makes sense to keep oversight
- Functions should go to the local
- Should have oversight groups
- There should be a review committee to participate at the state level
- If no oversight, consumer and family members might not be heard
- Not including community and stakeholders
- Have some state contact for consumer and family member to contact. Inclusive process at the local level
- Who has the authority?
- Don't split up functions/ Mental Health Services Act components
- Keep it simple. No fragmentation
- Issue resolution, keep it at the state
- Data collection → increase funds for this service
  - Have not been able to access data
  - Struggling to get good data
  - Put up funds towards these function
  - Need more state programming
- Consumers using HMIS to entice data
- Alcohol and drug Program system works and will be easy
- Data Collection
  - How counties work?
    Counties operate at the Behavioral Health cultured competency. Report people should look. Slow process to review plans.
    Housing → stay at Department of Mental Health. California Association of Local Mental Health Boards has been effective. Remain the same and keep principles intact.
    - California Association of Local Mental Health Boards interaction has been positive
    - It should be at the local level
    - No need ??? to the state
  - If complicate, it's good to have a state entity.
    Technical Assistant assistance at the state
  - ??? Corporation housing → they coordinate at the local, state and federal
  - Figure out the needs at the local level
  - Decisions should be at the state level
  - Approval of housing should be at the local level
  - Keep fragmentation at the minimum
  - Innovation Plan – counties take time to develop innovation
  - Eliminate Mental Health Services Oversight and Accountability Commission
  - Office of Multicultural Services- what can really be measured

- Innovation plan reveal responsibilities to CiMH

Office of Multicultural Services

- Increase funding to reduce disparities
- Continue to keep funding
- Be able to have statistical system to look at data

Co-occurring Disorder

- Don't forget co-occurring
- They are setting bounced around
- Don't forget about his
- Substance Abuse and Mental Health – staff should be able to work with this group
- Integration of services Substance Abuse and Mental Health
- Be careful about oversight
- The organization that takes over co-occurring should meet with COJAC
- Limited to made decisions
- Soldiers → DHS should be involved ??? and suicide prevention
    - Not getting services from the federal
    - Local government cannot help and provide all service needed
- Office of Multicultural Services → Need to have accountability that counties are increasing penetration rate.
- Need oversight (Local or State) in cultural competency services.
- Oversight should be at the state or other entity and not at the local level.
- Actability of multicultural services should be at the state.
- At the state level can be managed and with county input.
- Ethnic services coordinators should review/oversight
- State should help the local level to move forward
- Two way coordination between state and local

Training

SMHI

Early Mental Health Initiative

Substance Abuse and Mental Health Services Agency → Should be in one place. Keep it at the state

- Transfer to Alcohol and Drug Program or Department of Health Care Services

PATH→ It should go with the other grants

Workforce, Education and Training → Keep at Department of Mental Health. Too many parts to be moved.

- People that have been involved at Department of Mental Health have been great and knowledgeable.

Training contracts → External Quality Review Organization funds should be transferred towards data collection.

- Use funds to help the local level
- Re-prioritize; re-bump
- Training toward more data driven
- Need statistician to analysis data. Data should be analyzed from county to county.
- How do we get people to qualify for Medi-Cal to alleviate workload
- Include – Co-op unit working with Department of Rehabilitation to provide Technical Assistant to counties
- Mental Health consultation to Department of Rehabilitation is being missed
- Department of Rehabilitation not looking at the recovering model
- Co-op unit was effective
- Caregiver Resources Center→who establishes the guidelines, licensing and certification.
- Measure the level of motivation among clients
- Motivation as an outcome measure
- Capture motivation
- How to improve motivation among clients
- Peer movement
- Education about illness. How to recognize the symptoms
- More forward toward humanistic reflection

Providers, Advocates, Clients

- Providers communities better way to specifically serve their area – more "tailoring" to their need
- Find extra resources that would go to local level? [Extra money that won't fund state staff.]
- Opportunity for counties to get greater resources
- Local advocates may have greater access.
- Opportunity to integrate mental health services with Alcohol and Drug programs
- To assist in housing for homeless
- Greater opportunity for community oversight
- Opportunity to integrate private and public mental health systems – to provide more support for homeless
  -Private (if non-profit) – one person only wants non-profit
  -One person wants to incorporate public and private
- More coordination between schools – more mental health services for children
- Increased local accountability and transparency regarding local services
- Increase resources by reducing duplication of services on state level
- Improve communications – campaign strategy "customized" to local level.
- Bring education about mental illness to local community groups
- Increase clients education that will result in employment
- Reduce redundancies in reporting

- Look at how we coordinate services for kids and increase availability
- When Alcohol and Drug are mental health are joined, - greater co-occurring services at local level. If state combines, state might be better coordinated between both sides, make it easier to treat both at same time.
- Mental problems with Mental Health – better local integration of services
- Client says she's greatly benefited by co-occurring treatment. Treat people as while person.
- Develop a "continuum of care" – from most expensive (intensive) treatment to least expensive
- For adult care – multi-disciplinary teams to treat multiple issues
- Provide more care for teens
- Get more anger-management services for teens
- With Conrep – Consumers and family members – greater role and advocacy
- Present and promote "recovery model" – holistic medication or not, music, art, nutrition, etc.
- Better communication between Medi-Cal functions and non-medical providers
- Employment services, vocational training and pre- vocational services, training.
- Attention to services for foster children and assistance for transition out of foster care.
- Education elected officials in supporting local mental health services by providers' adequate resources
- Identify and blend more efficiently – the services that already exist – more "comprehensive"

Question #2 Comments

- Financial oversight has been 20 years of hard work to get a system that works well – concerned about changing it – Don't take something that works well to another department that doesn't know.
- Mental Health Services Oversight and Accountability Commission – because we need to look at integrating with each county
- Like to see funding for programs in county to treat people so they don't end up in prison.
- Like to see greater funding of Laura's Law – county to implement
- Prefers regional county organization to have influence

Break-Out Themes

- Co-Occurring (w/Medical disorders)
- Medical model
- Continuum of Care
- Adult care to mirror youth services (MDT)
- Services for teens
- Focus on Conrep
- Promote recovery in holistic approach
- Local control
- Tailoring services where they are most needed
- Streamline/Efficiency
- Less duplication
- Alignment of Mental Health and Alcohol and Drug
- Financial issues – cooperative effort between state/local
- Training and technical assistance needs to be more focused
- External Quality Review Organization out-lived usefulness
- Local resources
- Opportunity for integrated private/public service
- Coordination with schools
- Opportunity for community oversight
- Increase client education – stakeholders
- Outcome measures – not counting people but looking at quality and effectiveness
- Housing at local level
- Accountability for cultural competence
- Co-occurring issues in everything
- Veterans need to be served across systems – no wrong door

Break-Out *Counties*

What opportunities do you see as a result of this transition?

- You can put services where they are needed the most. In the counties where they "don't know what they are doing" you can provided more focused TA.
- Tailoring services to local culture
- Local control
- 50% to "Really Excellent" and less to "medicare" – free market system
- Alignment of Mental Health services and alcohol and drug services – coordinated
- Streamlined services → efficiency
- Less duplication

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

FUNCTIONS

- It almost doesn't matter, unless we are talking about setting rates (i.e. social service foster care rates). Or, is this more about management of programs? This is more about management. Direct services are carried out at the local level
- There are mandates in place about amount of funding for children and older adults.
- What is meant by financial oversight?
- Housing includes payments for homeless consumers to rent post office boxes
- Has the state done anything with the Stigma and Discrimination program? We initiated some discussion/collaboration with federals before the funding was diverted to California Mental Health Services Act. But Department of Mental Health oversees the whole program.
- Some mentally ill people shouldn't be housed in the correction system.
- Is it even possible for financial oversight to happen at the local level?
- Department of Health Care Services administers Medi-Cal so issue resolution should go there too.
- Data sent to the state goes into a big black hole and is never seen again.
- The state should contract with an entity (like UC Berkeley) to do something with data collection.
- Locals could also get/hire contractors to do this data work
- If it stays at the state, there is statewide data available compare between counties
- Suicide prevention/stigma needs to stay 75% local level
- Develop a division with in Department of Health Care Services to do prevention work (includes suicide, SMHI, stigma)
- Rather than re-creating the wheel in each county, a state entity can do some of that research/comparison (for stigma)
- Veterans mental health is under funded
- I see the veterans mental health functions being eliminated – this should happen at federal level
- For Workforce, Education and Training, would California Department Education take on some of these responsibilities? Monitoring stipends, etc!
- Leave training contracts with California Institute for Mental Health
- Eliminate technical assistance as a state level function

What do you believe are the challenges associated with the changes to mental health at the state level? How can these challenges be addressed?

- Not mentioning the mental health board at the state level California Association of Local Mental Health Boards.
- How is the integration of services going to "mesh" if the functions are dispersed all over?

- Re: Contract funds: where is the funding going to come from to fund all of the identified functions at Department of Mental Health
- There needs to be accountability and oversight efforts from consumer and family members (local level)
- Can contract funds be re-allocated to provide more money for administration of services (functions)

Appendix X

Notes from City of Berkeley Regional Stakeholder Meeting September 6, 2011

CALIFORNIA DEPARTMENT OF Mental Health

2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES

DATE: September 6, 2011 LOCATION: City of Berkeley, CA

Participants

02	Consumers/Family Members/Consumer Advocates
05	Providers
08	County Representatives
05	Other
03	Phone Participants
23	**Total Participants**

Pre-Meeting Education Session- Questions/Comments

- How can we be assured that counties spend the MHSA funding as mandated in Prop 63? The Conference Committee set up services for the sub-division of CSD. Housing Subdivision was given more responsibility for MHSA services.
- Consumers do not have money for computers to print/access information about the process and background documents. DMH attempted to make all of the meetings as accessible as possible. Consumers can also ask their Local Boards/Commissions to support their participation

Background and Context Questions/Comments

- Is the DHCS Deputy Director position definite? Yes, it was created as a result of AB102 and AB106
- Are you going to discuss other mental health divisions? What about the [new] Department of State Hospitals? What about forensics programs? There will be a state department (to be named later) to administer/oversee state hospitals with that singular focus.
- Will the Office of Multicultural Services stay intact? If that is what the stakeholders ask for, that is what will happen.
- If functions go to the counties, will the money/resources go with them? Realignment (AB100) directed $861m to counties for EPSDT and Managed Care. AB3632 moved to CDE.
- With all of the responsibilities coming to the local level, will there be enough money that follows? Specifically for AB3632, etc. Negotiation of budget/resource allocation is happening at the Legislature, Department of Finance, and the Governor's level. The Governor is pursuing revenue increases, but nothing has passed yet.
- San Francisco clients are concerned that when this transition happens we need to take the best practices, especially recovery principles; and, Medi-Cal billing codes need to go over too, to ensure consistency in billing, etc. DHCS negotiated getting mental health staff to go with the functions. They need people who have the expertise.
- DHCS has [historically] been responsible for health services. We want to make sure that the mental health functions don't get lost. We don't want to go back to the medical model. We spent years fighting for the recovery model.

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

- What will happen with the currently scheduled audits? Will there be a new surge of audits that changes the schedule? They are preparing for this huge transition. The official merger happens on September 1st. DHCS is looking at the current audits and assessing what should happen with those The Program Compliance staff (from DMH) is going over to DHCS.
- What about MHSA audits? Tell us what you think, where should it go? But, we don't do "audits" of MHSA programs We [previously] did plan reviews and expenditure/fiscal reviews
- Is there a plan to train DHCS staff in the recovery model? Why are some of the cuts not happening at DHCS to ensure a more balanced staff for health and mental health? Where is the mental health expertise going to come from, especially since so many jobs were lost at DMH? Those jobs were not "lost" Many of the staff positions were transferred to DHCS. Others were placed in other state departments.

Based upon today's presentation, what are the changes in mental health at the state level that stand out for you?

- What stands out is what is not being said regarding the implementation of the MHSA. Where is the "fix"? When will the conversation about the two tier system be addressed?
- Will the commitment to MHSA transformation/principles still be there? What about the state oversight to ensure local commitment to these principles? What is the role of the MHSOAC? Counties have been implementing MHSA programs for six years They meet regularly with stakeholders. Boards and Commissions, and Boards of Supervisors; they have built in checks and balances
- How can we really address mental health when everything is now about Medi-Cal? MHSA programs are not going away; the counties will just have more local control.
- What about the Department of Alcohol and Drug Programs? AB106 moves the Drug Medi-Cal functions to DHCS.
- How will dually-diagnosed people be addressed? You tell us, in small group break-outs
- Who is the oversight body to ensure that counties are appropriately implementing MHSA programs? Not just for the reversion. What happens to plan approval at the state level? What is the future process? The state doesn't currently have authority for plan approval

What opportunities do you see as a result of the transition at the state level?

Providers/Consumers/Family Members/Consumer Advocates

- DMH can teach DHCS expertise related to getting away from the medical model.
- Less bureaucracy
- Learn from consumers; change from the ground up
- Streamline billing and documentation system
- Disallowances for Medi-Cal
- Un-silo funding; streamline the process

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

- Concerned about losing services; will new Medi-Cal services help to restore funding for services?
- I am concerned about the due process measures that will be put in place for clients and family members.
- The client and family member voice needs to be built into the mental health system regardless of who "takes over"
- Voice of cultural competence for Native American communities for community defined practices
- We need to remember individuals that we are serving; keep them from falling through the cracks.

County Representatives

- I am concerned about resources.
- I am concerned about the status of the Department of Rehabilitation cooperatives
- Opportunity to join the national effort on health care reform and other changes happening at the federal level.
- Overall, how much money is the state losing vs. how much money is coming to the local level? How much is lost? Not sure that any funds will be lost; it will be distributed on a more regular basis but without the state in the "middle".
- How are the allocations determined? AB100 defines the allocation formula.
- There is no accountability with this new structure to ensure that money goes to what it is supposed to go to (MHSA). There are other checks and balances at the local level, the MHSA still has oversight of PEI and Innovation.
- Some federal opportunities have been lost due to leadership at DMH. For example, EBP for Cooperative Employment developed by Dartmouth is looking for state partners.
- Take a look at and audit the cooperative programs that are out there. CalMHSA wants to take on more responsibility for statewide projects; consider CalMHSA as an option Alameda County has not chosen to be a part of CalMHSA at this time. Another proposal is to create a joint department combining alcohol & drug programs and mental health services (possibility a state Department of Behavioral Health Services, to be named later)
- Employment services, peer support, etc. are not currently reimbursable under Medi-Cal.
- Opportunity for jurisdictions to invest in community defined practices.
- Concerned about going back toward a medical model.
- Opportunity to address specific community needs.
- Opportunity to address co-occurring disorders.
- Improve efforts toward integration, person with multiple needs so that you can address all of those needs. It would be wise for California to follow the lead with federal health care reform. Aside from concerns about the medical model, we should integrate with physical health. We also need same day billing.
- Physical health and mental health integration (co-location)
- We need to focus on older adults
- Integrated funding/services especially related to AOD services (multiple funding streams). We need it at the state level; we don't know what will happen with federal health care reform.

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

- Opportunity to focus on integration/co-occurring disorders and "fuse it all together". It needs to be under DHCS to align with federal effort but there needs to be stand-alone leadership (Deputies) with expertise in AOD and MH.
- Can't forget about persistently SMI population, no day programs for those individuals
- On-going auditing for outcomes, performance measure, on-going goals. We need to continue to make sure that we are giving the best services to people. I am concerned about the loss of oversight. We need to identify what is working well and stick with it.
- Who will be monitoring implementation of plans to ensure adherence to the plan? Issue resolution track- what is the state function involved in that? It is helpful to have a non-city/county option. The MHSOAC and the CMHPC are still options for issue resolution.
- The functions need to naturally fall into the scope of the other functions at the agency, align with similar functions.

Which entity should assume responsibility for the functions/programs listed? What functions/programs are missing from the list?

Providers/Consumers/Family Members/Community Advocates

- For program oversight, we need to get oversight at the front end
- I want oversight of the money, but fear that if it is DHCS it will only be a medical model agency
- Issue resolution needs to be with a separate entity, independent from county and state. Use best practices from other states (Massachusetts). Who has the "teeth" to make things happen? We need to clarify the process and make decisions based on resolution.
- FSP data does not give information on the system of care; only a small percentage of consumers is involved in data collection
- Data does not capture the quality of services. We need to improve the quality of data, what gets captured, not just reflective of the number of people in the door.
- Housing decisions should be based on the Senate Office report and follow the recommendations in the report
- The state needs to keep responsibility for co-occurring disorders; to get it started we need to use best practices; remove barriers regarding effectiveness

County Representatives and Providers

- EQRO is a great venue; but they weren't very substantial. It's something that should be reviewed/evaluated to make it more robust. DHCS is looking at the federal requirements for EQRO. Some people are champions of EQRO, others are not. EQRO currently scheduled to go to DHCS They are looking at the review cycle- is one year ok? Should it be a three year cycle? How do consumers get involved in the EQRO process? How do we get information? NAMI CA, Network, Pool of Consumer Champions, etc. That should be an open process, not just selected people.
- Everyone has to spend so much time with data to justify services for financial oversight purposes and this leaves less time for actual services.
- Financial oversight should go with the other functions to DHCS.
- What about CalMHSA? Over 40 counties have joined to date.

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

- Is it a certainty that DMH/ADP will go to DHCS? It is a certainty that Medi-Cal will go over to DHCS. The non Medi-Cal functions are what this process will determine
- As these organizations take on more responsibility, they are going to have to re-organize to provide adequate oversight. Along with that, people will need resources
- DMH has enough understanding of operations (specific details/knowledge of program approach) but CalMHSA might be better at the statewide financial functions of the programs.
- What is included in the Housing functions? It is strictly financing through CalHFA.
- The state needs to have some oversight of housing. Without the state, folks would be underserved. But there should be increased local control.
- There needs to be local input into programs, counties are so different.
- I can see CRC's getting lost at the local level due to lack of prioritization of the program.
- Decisions about CRC's have to be made locally, but DMH needs to be the promoter.
- Combining ADP and DMH in a unified approach would help with SAMHSA (etc.)
- The CMHPC is involved in all of these functions, but they only meet quarterly.
- Veteran's services should have some state oversight. It should go under a joint DMH/ADP agency. Better linkage with non-profits that serve veterans.
- Coordination of county disaster response could happen at CIMH.
- How could locals be responsible for monitoring of compliance/quality improvement/program evaluation when it is the local programs that are being evaluated? Locals are required to have a program evaluation component in their contracts.
- Contract funds for Cooperatives (DoR) went unspent because counties didn't know how to access the funds. Locals need to work with ADP/DMH and CalMHSA (and CIMH) to promote these programs.
- There has to be better coordination about what is available through SAMHSA.
- PATH and Housing should go to the same place.
- CA is really behind in CIT.

What do you believe are the challenges associated with the changes to mental health at the state level? How can these challenges be addressed?

- The funding issue; resources are limited. We need to look more at natural/community supports (like faith centers, etc.). The State shouldn't be responsible for meeting all of the needs.
- There is still, despite MHSA, a discrepancy in services that needs to be addressed.
- Orient local jurisdictions to the changes. Have a media campaign and concrete technical assistance to help local stakeholders.
- Looking at the cultural competency piece of MHSA, you need buy-in. We need to keep people accountable.
- Accountability is very important. Who is doing this? Who is in charge?
- Making sure that there is advocacy for cultural competence. We don't have enough information about the history/functions (especially the Office of Multicultural Services).

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

- We need to ensure that the merging of ADP and DMH [into DHCS] is about integration not cohabitation. We need goals, detailed assessments, and outcomes measures. There will be differential philosophies and we need to overcome that by identifying common goals.
- We need an improved Ombudsman Office.
- There is a push and pull between locals and the State. In some counties, the local county is the best place. In others, the State is best. The State needs "teeth" to provide technical assistance to struggling counties.
- We need to go back and look at programs that have been lost, or not implemented as they were indicated in the planning phase. There is a risk of that happening without program oversight.
- Oversight at the state level to ensure that people get services, not screened out because they don't have Medi-Cal. Make sure that people get the help that they need.

Phone Participants

- We need to look at cultural needs overall and expand accountability about how we invite stakeholders to the process. Make sure folks are really getting to the table.

Appendix XI

California Mental Health Directors Association (CMHDA) Recommendations

State Administration of Community Mental Health -

California Mental Health Directors Association (CMHDA) Recommendations

September 7, 2011

Introduction

The administration of community mental health programs in California is undergoing significant change. The 2011-12 state budget and associated trailer bills authorized the transfer of all Medi-Cal functions to the California Department of Health Care Services, realigned Medi-Cal Specialty Mental Health from the state to counties, and significantly changed the state's responsibilities for administering the Mental Health Services Act (MHSA). Additionally, the Governor has proposed to eliminate the California Department of Mental Health (DMH) and Department of Alcohol and Drug Programs (DADP), and create a new Department of State Hospitals. In light of these momentous shifts in the state's role in community mental health, DMH is soliciting input from community mental health stakeholders about the future of state administration for non-Medi-Cal programs and services.

This paper provides recommendations about the state administration of non-Medi-Cal community mental health from the perspective of county mental health departments, as represented by the California Mental Health Directors Association (CMHDA). The paper provides CMHDA's recommendations in two central ways: 1) Identifies the state entities that might be best positioned to perform specific DMH functions, should DMH be eliminated as the Governor proposed, and 2) Identifies opportunities for improvement in the future administration of each function.

Oversight of County Mental Health

State Entity Roles

CMHDA agrees with the sentiment in Governor Brown's January 2011-12 state budget, indicating that his Administration wants to allow "governments at all levels to focus on becoming more efficient and effective, facilitating services to be delivered to the public for less money." Additionally, we agree that duplication and overhead costs should be reduced and minimized. To that end, we believe the appropriate state-level administrative body for non-Medi-Cal community mental health services would be the **Department of Health Care Services (DHCS)**, which is already taking on the administration of Medi-Cal Specialty Mental Health. We

believe it would be most efficient for one state department to provide oversight and technical assistance to county mental health agencies, as well as focus on policy leadership and performance outcomes across various community mental health programs. Additionally, given the major shifts in our nation's health care policies, we believe an integrated focus on mental health, substance use, and physical health is more feasible if the various government healthcare programs are administered by one state entity.

We are pleased that DHCS has already made clear a commitment to creating high-level leadership positions for community mental health and substance use disorder programs in the area of Medi-Cal administration. However, within the large, health and Medi-Cal focused structure of DHCS, it will be vital to ensure an ongoing commitment to California's community mental health system. Adequate, high-level leadership within DHCS would be charged with promoting mental health, wellness, resiliency and recovery in California's diverse communities.

Opportunities for Improvement

- Streamline Compliance and Auditing: The compliance and auditing activities the state and counties conduct for community mental health should not be duplicative and needlessly time-intensive across programs. Compliance and reporting requirements should be no more burdensome than existing federal and state laws, and should provide valuable information to decision-makers and the public about the community mental health system's performance in assisting consumers with recovery and wellness. Reducing counties' required administrative activities would help counties maximize available resources to provide direct consumer services.

- Focus on Performance Outcomes: A vital function seriously lacking in the current state-level administration of community mental health is performance outcomes monitoring. We would strongly support a state-level administrative body that:

    - Develops the annual state-county performance contract, which outlines the statutory and regulatory responsibilities of counties in their role as contractors for the state;
    - Establishes, collects, analyzes and publishes performance measures and quality indicators for all community mental health programs and funding streams. This can be done directly or with research entities by contract;
    - Supports counties in their efforts to collect and analyze data by providing support to those that might need assistance in conducting more rigorous data collection and evaluation;
    - Facilitates county quality improvement efforts and ensures that the technology at the state level is able to accept and meaningfully use the information it receives from counties;

- Develops necessary state regulations for community mental health (including MHSA) services, while promoting the integration of overlapping federal, state and local requirements; and
- Provides support to each county to promote its success in implementing a recovery-focused community mental health system, and achieving positive outcomes for consumers.

- Focus on the Existing Performance Contract: While program administration and delivery of services is the responsibility of counties, it remains the responsibility of the state to ensure that counties administer the programs and delivery of services in accordance with applicable state and federal laws. An annual performance contract is required by statute. Through execution of this contract, the state authorizes county expenditure of funds. As stated later in this document, we believe language should be incorporated into the county performance contract that requires compliance with the existing statute for county submission of the MHSA Three-Year Plan and annual update.

  The state annually revises the required content of the contract to identify changes in the applicable laws and the information required to be submitted by counties to determine that each county is in compliance with each applicable law in its administration. A vital state function is to review these submittals and to certify that each county is in compliance. State statutes identify an additional state function in circumstances in which the state determines that a county is in serious violation of state or federal laws and corrective action is required. State agency staff is required to evaluate when such action is warranted, and what corrective action must be taken.

- Better Utilize Existing Oversight Bodies: Existing policy and oversight bodies need not be re-invented. There are already existing policy and oversight bodies specified in statute -- the California Mental Health Planning Council and MHSOAC -- that include stakeholders and advocates who play a role in informing the state on their perspectives regarding the important policy issues impacting the community mental health system.
  These two bodies help ensure adequate, high-level leadership within state government that help promote mental health, wellness, resiliency and recovery in California's diverse communities.

  There are also statutorily-required local public input structures and processes in existence today, such as the Local Mental Health Boards and Commissions and the MHSA local planning process, which assure the participation of community members in the design and implementation of the community mental health system in each county. These statutorily required structures act in an advisory capacity to county government and the county Boards of Supervisors. In the future, we believe an assessment of the functions of the Mental Health Planning Council and MHSOAC could be conducted to identify areas of potential consolidation.

Multicultural Programs and Cultural Competency

State Entity Roles

CMHDA strongly supports the state's ongoing commitment to ensuring cultural competence and reducing disparities remain a strong focus in the new organizational structure of state administration of health care and community mental health. We believe **DHCS** could play this role and is committed to these goals, as evidenced by the contents of its draft transition plan for Medi-Cal Specialty Mental Health. For example, the transition plan already identifies that one of DHCS' planned activities is to identify DMH's current requirements and processes and develop policies and a plan to assure Mental Health Plan (MHP) accountability for cultural competence. We would suggest that DHCS work with counties and other appropriate stakeholders, including the MHSOAC, in this process.

Support for Mental Health Consumers and Their Families

State Entity Roles

CMHDA strongly supports the state's ongoing commitment to ensuring that support for mental health consumers and their families remains a strong focus in the new organizational structure of state administration of community mental health. We believe **DHCS** could play this role and is committed to this, as evidenced by the contents of its draft transition plan for Medi-Cal Specialty Mental Health. For example, the transition plan identifies a commitment to providing opportunities for meaningful input from consumers and family members, and identifies a number of new efficiencies/improvements that includes expanding peer support, reducing discrimination and stigma, and ensuring equal access to services.

Mental Health Services Act (MHSA) Administration

State Entity Roles

- Allocation of MHSA Funds: CMHDA supports the state maintaining the approach codified by AB 100 (Committee on Budget, Statutes of 2011), which requires the State Controller to distribute MHSA funds to counties on a monthly basis, based on a formula determined by "the state" in consultation with CMHDA. CMHDA recommends that "the state," for these purposes, should be the **Department of Finance** and the **State Controllers Office**. CMHDA has consistently supported the continuous distribution of MHSA funds to communities where they can be quickly utilized for direct consumer services. Additionally, this makes the distribution of MHSA funds comparable to the distribution of existing sales tax and vehicle license fees under 1991 Realignment.

- Mental Health Program Evaluation: We believe that the current "siloed" approach to community mental health evaluation has not served the legislature or the public well. It has provided little information regarding the results of expenditures for services and has created

a vacuum to be filled by opinion and anecdote. To be effective the evaluation efforts currently conducted by the Planning Council, the MHSOAC and the department need to be integrated and the results reported from a consumer, system and community perspective. While DMH may currently play a role in receiving data from counties, the department has historically been unable to conduct evaluation of counties' programs. The MHSOAC in collaboration with the Planning Council and DHCS are all uniquely positioned to focus their efforts on conducting adequate research and evaluation of community mental health programs in California.

- Statewide Prevention & Early Intervention (PEI) Projects: We believe the **California Mental Health Services Authority (CalMHSA)** is best positioned to administer the MHSA-PEI statewide projects (i.e., Reducing Disparities, Suicide Prevention, Student Mental Health, Stigma & Discrimination Reduction). This organization is already successfully administering nearly $130 million in counties' pooled MHSA funds in this area. We would recommend that CalMHSA ensure that it allows for administrative flexibility to small counties with unique needs and approaches to PEI statewide projects.

- Statewide and Regional Workforce, Education, & Training (WET) Projects: We believe **CalMHSA** is best positioned to administer WET statewide and regional projects. However, we would recommend that CalMHSA ensure that it allows for administrative flexibility to small counties with unique needs and approaches to WET. CalMHSA in conjunction with the Mental Health Planning Council would also need to begin development of a new 5-year statewide WET plan. Appropriate stakeholders should be reconvened to evaluate the first WET plan, and begin development of the new plan.

Opportunities for Improvement

In order to promote the efficient and cost-effective implementation of the voter-approved initiative, CMHDA recommends the state follow the clear language of the statute to maintain the intent of the voters and to reduce unnecessary regulatory and administrative burdens. Specific opportunities for improvement and efficiency in the administration of MHSA include:

- Maintain Prudent Reserve and PEI Policies: The existing MHSA prudent reserve policy should be maintained, which requires counties to deposit and withdraw MHSA funds from their prudent reserves [consistent with WIC 5847(a)7 and WIC 5892(b)]; additional state guidance is unnecessary. Similarly, existing PEI program requirements should be maintained based on WIC 5840; additional state guidance is unnecessary.

- Streamline Innovation Component: Consistent with WIC 5830, we recommend that counties expend 5% of their CSS System of Care (80%) and PEI (20%) funds on Innovation, rather than treat Innovation as a separate state MHSA set aside and allocation. Counties will develop Innovation programs as a part of the 3-year plan and update process and will expend the

Innovation funds consistent with the provisions of the MHSA; additional state guidance in unnecessary.

- Proposed Regulations: Consistent with AB 100, reevaluate and consider withdrawing currently proposed regulations for the following components of MHSA: Innovation; PEI; Capital Facilities; and IT.

- Performance Contracts and Plan Development: Incorporate language into the county performance contracts that requires compliance with the existing statute for county development of the MHSA Three-Year Plan and annual update.

- Remove Barriers to MHSA Housing: First, provide an option for counties to continue to utilize the current DMH/CalHFA program for their assigned Housing Program funding, or to withdraw their unused but assigned funds for use by the county for housing consistent with the MHSA. Additionally, consistent with the recommendations outlined in the recently released Senate Office of Oversight and Outcomes report on the CalHFA MHSA Housing program provide flexibility for small counties (population under 200,000). Second, remove the current state-imposed cap on housing operating subsidies and allow counties to determine the amount of their Housing Program funds dedicated to operating subsidies and capital costs. This recommendation may require amendments to current statutes.

Co-Occurring Disorders

State Entity Roles

As stated earlier in this document, we believe that having **DHCS** administer both mental health and substance use programs will provide an integrated focus on mental health, substance use, and physical health. Given the broad overlap among populations of individuals in need of mental health care, substance use disorder treatment, and primary health care, we think it makes sense that the variety of government programs in these arenas be administered by one state agency.

Licensing and Certification

State Entity Roles

We believe **DHCS** is the appropriate state entity to oversee and perform the function of licensing and certification of community based mental health treatment settings and specialty mental health providers.

Opportunities for Improvement

We recommend that DHCS license and certify or oversee the county mental health plans' certification of all types of facilities and specialty mental health providers serving individuals with mental health and substance use disorders -- including those currently licensed by

Department of Social Services (DSS) or Department of Public Health (DPH). We believe it would be beneficial to the care provided to consumers in these facilities if all of them were licensed, certified, reviewed, and inspected by one state department whose staff possesses behavioral health and recovery model expertise. Additionally, DHCS should also collect, maintain, and analyze data on the facilities, their programs, and consumer outcomes.

Currently, DMH or the county mental health plan licenses/certifies nearly all community treatment facilities serving mental health consumers. However, Adult Residential Facilities and Community Treatment Facilities are licensed by DSS-Community Care Licensing (CCL), and Skilled Nursing Facilities (SNFs) are licensed and monitored by the Department of Public Health (DPH). As currently structured, there is a direct conflict between the rehabilitation and recovery orientation of DMH licensing and certification, and the custodial or institutional focus of DSS-CCL. This serves as a barrier to the development of strong mental health residential resources, and jeopardizes our ability to meet Olmstead requirements.

SAMHSA & PATH Grant Administration

State Entity Roles

We believe **CalMHSA** could appropriately administer the SAMHSA and the PATH grant programs. CalMHSA might consider contracting with the **California Institute for Mental Health (CiMH)** to perform some of these administrative functions. Additionally, CalMHSA should aggressively pursue new federal funding opportunities that would benefit California's community mental health consumers.

Inter-governmental Activities

State Entity Roles

We believe **DHCS** could play the role that DMH currently plays in serving on (and making appointments to) various state and national boards and commissions where mental health representation is necessary or desired. This role could be played by either the new DHCS Deputy Director for Behavioral Health, or new DHCS Chief for Specialty Mental Health.

We also believe the new DHCS Deputy Director for Behavioral Health and/or new DHCS Chief for Specialty Mental Health should be active on SAMHSA task forces and committees and with the National Association of State Mental Health Program Directors.

Finally, the new DHCS Deputy Director for Behavioral Health and/or new DHCS Chief for Specialty Mental Health could play the role DMH currently plays in coordinating with other state agencies and departments on crossover issues that significantly affect mental health consumers (e.g., Department of Corrections and Rehabilitation, Department of Veterans Affairs, Department of Education-Special Education Division, Department of Social Services-CalWORKs and Child Welfare Administration).

Veterans Mental Health

State Entity Roles

As stated earlier in this document, we believe the new **DHCS** Deputy Director for Behavioral Health and/or new DHCS Chief for Specialty Mental Health can play the role DMH currently plays in coordinating with other state agencies and departments on crossover issues that significantly affect mental health consumers. An extremely important area for intergovernmental coordination would be on veterans' mental health. As you know, significant numbers of California's veterans have health and mental health care needs that may not be adequately addressed by federal programs. As a result, it is critical that the state administrative body for mental health possess knowledge about and a commitment to addressing the unmet mental health needs of California's veterans.

Lanterman-Petris-Short (LPS) Act Administration

State Entity Roles

We believe **DHCS** can play the role DMH currently plays in implementation of the Lanterman-Petris-Short (LPS) Act (WIC 5000-5587). Given the complexities of LPS, we encourage DHCS to work with counties and other appropriate stakeholders as it takes on this role.

Appendix XII

Principles to Achieve Oversight and Accountability in a Changing Mental Health Services Environment – Mental Health Services Oversight and Accountability Commission (MHSOAC)

MHSOAC

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Principles to Achieve Oversight and Accountability in a Changing Mental Health Services Environment

ADOPTED July 28, 2011

Background

The Governor signed legislation that shifts significant responsibilities for mental health programs from the state to counties and, in the May 16, 2011 Revision for budget year 2011-12, proposed eliminating the Departments of Mental Health (DMH) and Alcohol and Drug Programs (ADP). The proposed elimination of DMH and ADP is to occur in the 2012-13 fiscal year.

The Mental Health Services Act (MHSA or Act) established the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to oversee the MHSA and Mental Health Systems of Care.[1] The MHSA authorizes the MHSOAC to "advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness.[2]

MHSOAC FINDINGS

In implementing any reorganization, key findings are:

1. The state should champion a California-wide system that:

   - Reduces/eliminates stigma & discrimination
   - Strengthens mental wellness
   - Provides early screening and intervention of mental illness
   - Funds universal access to recovery based services in culturally sensitive settings
   - Evaluates programs for recovery model outcomes

2. Reorganization of state government and realigning services to counties offers an opportunity to transform and improve the mental health system in a way that is consistent with MHSA values. [3a-c]

MHSOAC PRINCIPLES

The Commission respectfully offers the following principles to help inform the Governor's and Legislature's decisions regarding reorganizing state mental health programs.

1. **The State* must continue to collect county data to support ongoing evaluation of California's mental health system.**[4a,b]
   A critical role in providing oversight and accountability is to conduct ongoing mental health program evaluation that focuses on outcomes and the appropriate and effective use of public funds. The MHSOAC through its statewide evaluation efforts strives to assure California taxpayers that the use of public funds for mental health services results in efficient investments, which achieve positive outcomes at local and state levels. In order to fulfill its responsibility for statewide evaluation,[4c] as well as its broader mandate for oversight and accountability, the Commission relies on data currently collected by the Department of Mental Health.

   Some functions important to this principle include accurate, timely data as well as efficient, accessible data systems.

2. **The State must continue to provide fiscal oversight for the expenditure of Mental Health Services Funds to ensure funds are being spent consistent with the Mental Health Services Act.**
   An essential element of oversight and accountability is to ensure to the Governor, Legislature, and taxpayers that the use of public MHSA funds is lawful, efficient, and prudent.[5a-d]

   Some functions important to this principle include appropriate public distribution of clear and understandable county fiscal reports that track at least component allocations and fund reversion.

3. **The State must continue to pursue and support efforts to reduce/eliminate stigma and discrimination related to mental illness.**
   Abuse of people with a lived experience of mental health challenges, as well as stigma and discrimination towards such people, their family members and the mental health professional community, are pervasive across lines of community, ethnicity, age, economic class, profession, media, and popular cultures.

* The Governor's May Revision proposes the transfer of some of DMH and ADP's current functions to the counties and the Department of Health Care Services during fiscal year 2011/12. The May Revise also proposes the creation of a Department of State Hospitals and proposes the elimination of DMH and ADP in fiscal year 2012/13. The term "State" in this document refers to the State entity that assumes the remaining functions of DMH.

One of the MHSOAC's responsibilities set forth in statute is to develop strategies to reduce stigma and discrimination associated with mental illness.[6]

Some functions important to this principle include producing data on this outcome and tracking the stigma and discrimination reduction efforts and supporting directly employing people with lived experience of mental illness and their family members, including those from underserved communities, throughout the mental health system.

4. **The State must ensure that the perspectives of people with serious mental illness and their family members are considered in MHSA decisions and recommendations.**[7a-c]
   Carrying out this mandate requires active and productive engagement of consumers and family members across the lifespan, including diverse racial and ethnic stakeholder communities, with the expertise that comes from lived experience of mental illness.

   A function important to this principle includes ensuring a robust stakeholder process in plan development, implementation, and evaluation. Compliance with this process should be part of the county mental health service Performance Contract.

5. **The State must continue efforts to reduce and eliminate disparities in access to, quality of, and outcomes of mental health services.**[8a-e]
   Not all races or cultures see mental health issues, symptoms or recovery in the same way. This, along with a history of discrimination, racial injustice, and trauma, has fostered systems in which disparities of access to and quality of care leave many racial and ethnic communities un-served, underserved, or inappropriately served.

   For the Mental Health Services Act to achieve its objectives, people should be served in ways that are coherent with and respectful of differing cultural views and traditions, in ways that eliminate disparities in access to treatment, quality of care, and create successful outcomes for all individuals and families being served.

   Some functions important to this principle include producing data that measures the service levels to underserved communities and tracking the effects of reducing disparities efforts.

6. **The State must ensure that counties are provided appropriate support, including training and technical assistance when appropriate, to achieve the outcomes that the MHSA specifies.**
   Counties need adequate resources to design, implement, and evaluate MHSA programs to achieve the desired mental health program and system

outcomes required by the Act. At times, this includes the availability of and access to training and technical assistance that includes the expertise and perspectives provided by clients and family members in addition to diverse community stakeholders. An important element of the Commission's oversight and accountability is to facilitate relevant and effective training and technical assistance.[9a,b]

A function that is important to this principle includes training and technical assistance that is guided by a) the priorities of counties; b) the priorities of people with serious mental illness and their families across the lifespan, unserved and underserved communities, and mental health providers, and c) research evidence regarding practices that support positive mental health outcomes.

CONCLUSION

The MHSOAC is establishing these principles to inform the decisions that will be made during the Administration's reorganization of mental health services. The Commission is available for consultation about the specific functions that we believe need to be maintained to support the State and Commissions ability to fulfill the requirements of the MHSA.

Endnotes of Relevant MHSA Statutes

1. MHSA Section 10, Welfare and Institutions (W&I) Code Section 5845(a): The MHSOAC is "established to oversee Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act; Part 3.1 (commencing with Section 5820), Human Resources, Education, and Training Programs; Part 3.2 (commencing with Section 5830), Innovative Programs; Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs; and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act."

2. MHSA Section 10, W&I Code Section 5845(d)(9): The MHSOAC in carrying out its duties and responsibilities may "at any time, advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness."

3a. MHSA Uncodified Section 2(e) (Legislative Findings and Declarations): "...These successful programs, including prevention, emphasize client-centered, family-focused and community-based services that are culturally and linguistically competent and are provided in an integrated services system."

3b. MHSA Uncodified Section 3(c) (Purpose and Intent): One of the purposes of the Act is "to expand the kinds of successful, innovative service programs for children, adults, and seniors begun in California, including culturally and linguistically competent approaches for underserved populations. These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of serous mental illness."

3c. Title 9 California Code of Regulations:

- Client Driven, as defined in Section 3200.050
- Community Collaboration, as defined in Section 3200.060
- Co-Occurring Disorders, as defined in Section 9550
- Cultural Competence, as defined in Section 3200.100
- Family Driven, as defined in Section 3200.120
- Integrated Service Experiences for clients and their families, as defined in Section 3200.190
- Wellness, Recovery and Resilience Focused, as described in Section 3200.160

4a. MHSA Section 15, W&I Code Section 5892(d): "The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division."

4b. MHSA Section 10, W&I Code Section 5848(c): "The (county) plans shall include reports on the achievement of performance outcomes for services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840, and

Part 4 (commencing with Section 5850) of this division funded by the Mental Health Services Fund."

4c. MHSA Section 10, W&I Code Section 5845(d)(6): The MHSOAC in carrying out its duties and responsibilities may "obtain data and information from the State Department of Mental Health, or other state or local entities that receive Mental Health Services Act funds, for the commission to utilize in its oversight, review, and evaluation capacity regarding projects and programs supported with Mental Health Services Act funds."

5a. MHSA Uncodified Section 3(e): One of the purposes in enacting this act is "to ensure that all funds are expended in the most cost-effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public."

5b. MHSA Section 10, W&I Code Section 5847(e): "Each year the State Department of Mental Health, in consultation with the California Mental Health Directors Association, the Mental Health Services Oversight and Accountability Commission, and the Mental Health Planning Council, shall inform counties of the amounts of funds available for services to children pursuant to Part 4 (commencing with Section 5850), and to adults and seniors pursuant to Part 3 (commencing with Section 5800). Each county mental health program shall prepare expenditure plans pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850), and updates to the plans developed pursuant to this section."

5c. MHSA Section 15, W&I Code Section 5892(g): All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.

5d. MHSA Section 15, W&I Code Section 5892(h): Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years, provided however, that funds for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the fund.

6. MHSA Section 10, W&I Code Section 5845(d)(8): The MHSOAC in carrying out its duties and responsibilities may "develop strategies to overcome stigma and accomplish all other objectives of Part 3.2 (commencing with Section 5830), 3.6 (commencing with Section 5840), and the other provisions of the act establishing this commission."

7a. MHSA Section 10, W&I Code Section 5846(c): "The commission shall ensure that the perspective and participation of members and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations."

7b. MHSA Section 15, W&I Code Section 5892(d): "The administrative costs shall include funds to assist consumers and family members to ensure the appropriate

state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services."

7c. MHSA Section 10, W&I Code Section 5845(d)(3): In carrying out its duties and responsibilities, the commission may "establish technical advisory committees such as a committee of consumers and family members."

8a. MHSA Uncodified Section 2(b) (Legislative Findings and Declarations): "No individual or family should have to suffer inadequate or insufficient treatment due to language or cultural barriers to care."

8b. MHSA Uncodified Section 3(c) (Purpose and Intent): One of the purposes of the Act is "to expand the kinds of successful, innovative services programs for children, adults, and seniors begun in California, including culturally and linguistically competent approaches for underserved populations."

8c. MHSA Section 5, W&I Code 5878.1(a): "It is the intent of this act that services provided under this chapter to severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and their family."

8d. MHSA Section 7, W&I Code 5813.5(d)(3): Planning for MHSA services shall "reflect the cultural, ethnic, and racial diversity of mental health consumers."

8e. MHSA Section 8, W&I Code 5822(d) & (i): The State Department of Mental Health shall include in a five-year plan for education and training of the mental health workforce, the "establishment of regional partnerships among mental health system and the educational system to expand outreach to multicultural communities, increase the diversity of the mental health workforce..." and "promotion of the inclusion of cultural competency in the training and education programs."

9a. MHSA Section 10, W&I Code Section 5846(b): "The commission may provide technical assistance to any county mental health plan as needed to address concerns or recommendations of the commission or when local programs could benefit from technical assistance for improvement of their plans."

9b. MHSA Section 10, W&I Code Section 5845(d)(7): "In carrying out its duties and responsibilities, the commission may do all of the following: ... Participate in the joint state-county decision making process, as contained in Section 4061, for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system."

Appendix XIII

NAMI CA Position Paper

NAMI California Policy Statement
DMH Reorganization

NAMI California supports the position of the creation of a new Department of Mental Health and Drug and Alcohol Services for all related non-Medi-Cal services and programs.

NAMI California believes that any reorganization of the State Department of Mental Health should provide individuals living with mental illness with services and supports that increase health and recovery outcomes across the life span, are culturally and linguistically competent, and are integrated and coordinated to provide linkage to needed treatment and services regardless of funding stream.

California should use this reorganization opportunity to truly integrate our Medi-Cal, **non**-Medi-Cal, and MHSA services to prioritize assistance to all Californians based on their severity of need.

As various reorganization proposals are discussed, NAMI California urges policy makers to answer the following questions:

- How will a reorganized Department of Health Care Services (Medi-Cal) and Department of Mental Health (**non**-Medi-Cal mental health) and increased localization ensure that children, youth, adults and older adults with **the highest or most complex mental health needs are prioritized?**
- How will reorganization ensure that a full array of services and supports are available, accessible, and culturally and linguistically appropriate throughout the state? In addition to traditional psychiatric services, an array of services should, at a minimum, include:
  - Housing with supportive services
  - Employment and education supports
  - Transportation services
  - Reduction in engagement with the criminal justice system
  - Wrap Around Services
  - Integrated mental health and substance use treatment
  - Prevention and outreach services
  - Case management and care coordination
  - Community skill building
- How can California prioritize services and supports by severity of need, rather than by source of funding?
- How can California facilitate decreased demand for state hospital beds and reduce rates of incarceration and re-hospitalization.

Any reorganization of California's mental health system can only be successful if it facilitates the coordination, integration, and linkage of Medi-Cal, non-Medi-Cal, and MHSA services. This integration must be accomplished in order to achieve positive outcomes for all persons living with serious mental illness.

To achieve this integration and coordination goal, NAMI California supports the position of the creation of a new Department of Mental Health and Drug and Alcohol Services for all related non-Medi-Cal services and programs.

State Hospital Care and Reorganization Proposals

Successful reorganization of mental health funding and functions should facilitate reduced demand (need) for state hospitalization, improved health and wellness outcomes for patients and fewer instances of re-hospitalization.

California will need to decide if:

- A new Department of State Hospitals be created under the Health and Human Services Agency;
- Or, the responsibility for the state hospital system remains within the domain of a new community-based mental health care department as described above.

NAMI California calls for a comprehensive review and analysis of the pros and cons of the above choices to determine the most appropriate placement of responsibility for California's state hospital services,. NAMI California does not support the transfer of state hospital responsibility for forensic patients to the Department of Corrections and Rehabilitation.

Senior Policy Advisor

- NAMI California believes any reorganization of California's mental health system can only be successful if it facilitates the coordination and linkage between Medi-Cal and **non**-Medi-Cal services and programs. This integration must be accomplished in order to achieve positive outcomes for all persons living with serious mental illnesses.
- Effective coordination and development of policy can only be accomplished at the highest level of California's health care system.
- NAMI California supports the concept of a senior policy advisor at the highest level of the Health and Human Services Agency.

Appendix XIV

Rose King Comments on Community Services and Supports Comments

Dear Mr. Allenby and Ms Baird

Below are excerpts from the document that defined populations of people with serious mental illness. As I reported in the Monday August 22 meeting, counties from across the state reported to DMH in their initial CSS plans that 95-100% of their clients were defined as "underserved/inappropriately served." Many reported 0% as "fully served." These are the numbers counties submitted in the "Chart A."

As consultant to then-Attorney General and OAC Commissioner Bill Lockyer, I worked in 2005 and 2006 to launch the MHSA and OAC implementation, working closely with DMH personnel. I managed a committee chaired by Commissioners Tricia Wynne (Lockyer designee) and Jerry Doyle of Santa Clara County, and we read all 56-58 CSS plans (300-1,000 pages)—and we sent OAC Comments on the plans to each county, as required by the statute.

Counties that reported 30-40% of clients as "fully served" were questioned as to whether they followed the DMH definitions, and we determined that they had used a variety of other definitions. One of the two commissioners or I represented OAC at the final review meetings in Sacramento, and we found that some mental health directors decided to count everyone with MediCal as "fully served" or used other interpretations independent of the ones provided by DMH.

In these personal interviews and follow-up OAC comments, we concluded that when counties used the DMH definitions, they indeed found that virtually all clients in public mental health system were underserved/inappropriately served. In the first two years of OAC operations, we made every effort to change DMH instructions to counties and ensure that MHSA services would begin to reach those people defined as underserved. We were not successful. Counties continued to spend MHSA revenue on new programs for newly recruited clients instead of improvements to the existing systems of care.

You may know that I am working with other people from around the state to continue to inform state and county executives of MHSA problems of waste, inefficiencies, and misuse of funds intended to raise the standard of service in existing systems—not create a new, independent program for a select few. Today, after seven years and $7 Billion distributions, the state and counties report that 24,000 people are fully served. On the face of it, we believe it warrants investigation. It is frankly painful to review the definition of underserved/inappropriately served and recognize that DMH chose to exclude these consumers in existing county programs from MHSA benefits. Thank you for your consideration.

Sincerely,
Rose King
Rking1@surewest.net

(COVER PAGE OF DOCUMENT—POSTED ON DMH WEBSITE AS LETTER 05-05, AUGUST 1, 2005)

Mental Health Services Act
Community Services and Supports
August 1, 2005
THREE-YEAR PROGRAM AND EXPENDITURE PLAN REQUIREMENTS
Fiscal Years 2005-06, 2006-07, 2007-08

This document lists all requirements for first MHSA plan to be submitted by counties—CSS Requirements August 1, 2005)

(PAGES 15-16 of the document define Unserved, Underserved/Inappropriately Served, and Fully Served populations.

Section II: Analyzing Mental Health Needs in the Community
Direction:
Following identification of community issues, counties must provide an assessment of the mental health needs of county residents and residents of American Indian rancherias or reservations within county boundaries, including adults, older adults and transition age youth who may have or have been diagnosed with serious mental illness, and children, youth and transition age youth who may have or have been diagnosed with serious emotional disorders. The intent is to recognize all those who would qualify for MHSA services, including those who are currently unserved, underserved or fully served, and identify their age and situational characteristics (e.g., homelessness, institutionalization or out-of-home placement, involvement in the criminal or juvenile justice system, etc.).

For purposes of this document the following definitions apply:

Unserved – persons who may have a serious mental illness and children who may have serious emotional disorders, and their families, who are not receiving mental health services. Examples of unserved populations described in the MHSA include older adults with frequent, avoidable emergency room and hospital admissions, adults who are homeless or incarcerated or at risk of homelessness or incarceration, transition age youth exiting the juvenile justice or child welfare systems or experiencing their first episode of major mental illness, children and youth in the juvenile justice system or who are uninsured, and individuals with co-occurring substance use disorders. Frequently, unserved individuals/families are a part of racial ethnic populations that have not had access to mental health programs due to barriers such as poor identification of their needs, provider barriers lacking ethno-culturally competent services, poor engagement and outreach, limited language access, limited access in rural areas and American Indian rancherias or reservations and lack of culturally competent services and programs within existing mental health programs. Some individuals, who should be considered in the priority populations identified in Section III of this document, may have had extremely brief and/or only crisis oriented contact with and/or service from the mental health system and should be considered as unserved.

Underserved/inappropriately served – individuals who have been diagnosed with serious mental illness and children who have been diagnosed with serious emotional disorders, and their families, who are getting some service, but whose services do not provide the necessary opportunities to participate and move forward and pursue their wellness/recovery goals. This category would also include individuals who are so poorly served that they are at risk of situational characteristics such as homelessness, institutionalization, incarceration, out-of home

placement or other serious consequences. Examples of people who are underserved or inappropriately served include older adults who are in institutions because they are not receiving services that would allow them to remain in their own homes, adults who are in Institutions of Mental Disease (IMDs) and Board and Care facilities but not receiving services that would allow them to move to more independent and permanent housing, transition-age youth who are not getting the vocational services they need to become successfully employed, and/or children and youth who may be receiving mental health services in out-of county placements, but do not have the in-home supports needed to allow them to return home with their families. Frequently, underserved individuals/families are a part of racial ethnic populations that have not had access to mental health programs due to barriers such as poor identification of their needs, provider barriers lacking ethno-culturally competent services, poor engagement and outreach, limited language access, limited access in rural areas and American Indian rancherias or reservations and lack of culturally competent services and programs within existing mental health programs.

Fully served – People who have been diagnosed with serious mental illness and children/youth who have been diagnosed with serious emotional disorders and their families, who are receiving mental health services through an individual service plan where both the client and their service provider/coordinator agree that they are getting the services they want and need in order to achieve their wellness/recovery goals. Examples of people who may be fully served include individuals in AB 34 or 2034 programs and children and families receiving Wraparound services within a comprehensive Children's System of Care.

Although counties may also elect to provide some new or expanded services to underserved individuals already receiving some services in their system, DMH expects counties to identify unserved individuals and their families in the priority populations for MHSA funding.

(I put above section in bold because it launched the separate MHSA system. This section directs counties to identify and direct MHSA funds to unserved individuals—this is foundation of the two-tier or "dual system" identified as chief stakeholder complaint in three DMH implementation studies posted on website.

Please Note the definition of "Underserved/Inappropriately Served," the individuals who are essentially excluded from MHSA benefits—and the people who represent at least 90% of public mental health system.

(PAGES 18-19 of the document Includes Chart A, where counties indicate numbers fully served and underserved/inappropriately served, as explained in this section.)

Using the format provided in Chart A, indicate the estimated total number of persons needing MHSA mental health services who are already receiving services, including those currently fully served and those underserved/ inappropriately served, by age group, race ethnicity, and gender. Also provide the total county and poverty population by age group and race ethnicity. (Transition Age Youth may be shown in a separate category or as part of Children and Youth or Adults.)

The DMH's expectation is that counties will identify the number of persons, by age group, race ethnicity, gender and primary language, that may be underserved, including individuals that some might define as inappropriately served such as:
- An older adult with frequent emergency room visits who has not had a comprehensive medical, mental health and social assessment
- An adult living in an IMD or a Board and Care facility because of the lack of supported housing services
- A transitional age youth who does not have a comprehensive plan for transitioning out of foster care, or
- A child/youth living in an out-of-home placement or involved in the juvenile justice system due to lack of access to appropriate community-based services

(Pages 20-21 of the document instruct counties to give priority to unserved populations. Further, if they choose to serve other populations such as "underserved/inappropriately served," counties must specify reasons that these populations are more appropriate. As a practical matter, counties of course did not choose more work and more complications and thus excluded underserved.)

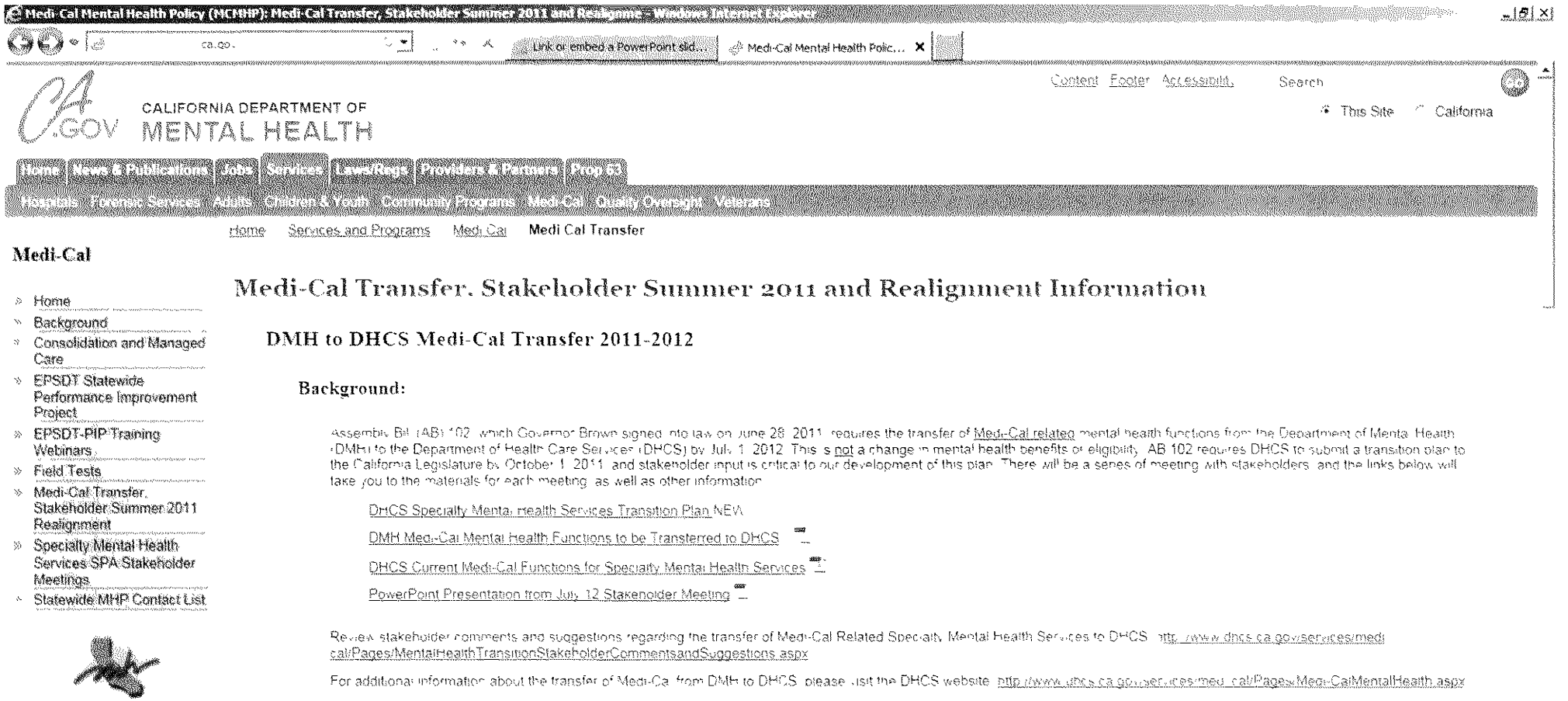
Counties must determine, through their planning process, which populations are the most appropriate to focus on during the first three years. These decisions should be made in the context of the community issues and mental health needs identified in the two previous sections. **Priority should be given to unserved populations.** What follows are recommended initial populations within each age group that are consistent with issues of public concern and the MHSA. **Counties who choose not to select from the initial populations in each age group as described below must specify their reasons for not doing so,** provide clear information as to why the initial populations they identify are more appropriate for this Program and Expenditure Plan, and describe how they are consistent with the purpose and intent of the MHSA.

Appendix XV

DMH Website, Facebook, Twitter Pages

DMH Website: Medi-Cal Transfer, Stakeholder Summer 2011 and Realignment Information

http://www.dmh.ca.gov/Services_and_Programs/Medi_Cal/Medi_Cal_Transfer.asp



Medi-Cal Mental Health Policy (NCMHP): Medi-Cal Transfer, Stakeholder Summer 2011 and Realignment - Windows Internet Explorer

Link or embed a PowerPoint slid... | Medi-Cal Mental Health Polic...

Content | Footer | Accessibility | Search | This Site | California

CALIFORNIA DEPARTMENT OF MENTAL HEALTH

Home | News & Publications | Jobs | Services | Laws/Regs | Providers & Partners | Prop 63

Hospitals | Forensic Services | Adults | Children & Youth | Community Programs | Medi-Cal | Quality Oversight | Veterans

home | Services and Programs | Medi Cal | Medi Cal Transfer

Medi-Cal

- Home
- Background
- Consolidation and Managed Care
- EPSDT Statewide Performance Improvement Project
- EPSDT-PIP Training Webinars
- Field Tests
- Medi-Cal Transfer, Stakeholder Summer 2011 Realignment
- Specialty Mental Health Services SPA Stakeholder Meetings
- Statewide MHP Contact List

Medi-Cal Transfer, Stakeholder Summer 2011 and Realignment Information

DMH to DHCS Medi-Cal Transfer 2011-2012

Background:

Assembly Bill (AB) 102, which Governor Brown signed into law on June 28, 2011, requires the transfer of Medi-Cal related mental health functions from the Department of Mental Health (DMH) to the Department of Health Care Services (DHCS) by July 1, 2012. This is not a change in mental health benefits or eligibility. AB 102 requires DHCS to submit a transition plan to the California Legislature by October 1, 2011, and stakeholder input is critical to our development of this plan. There will be a series of meeting with stakeholders, and the links below will take you to the materials for each meeting, as well as other information.

DHCS Specialty Mental Health Services Transition Plan NEW

DMH Medi-Cal Mental Health Functions to be Transferred to DHCS

DHCS Current Medi-Cal Functions for Specialty Mental Health Services

PowerPoint Presentation from July 12 Stakeholder Meeting

Review stakeholder comments and suggestions regarding the transfer of Medi-Cal Related Specialty Mental Health Services to DHCS http://www.dhcs.ca.gov/services/medi-cal/Pages/MentalHealthTransitionStakeholderCommentsandSuggestions.aspx

For additional information about the transfer of Medi-Cal from DMH to DHCS, please visit the DHCS website http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalMentalHealth.aspx

DHCS has also established a special email address for individuals to submit comments and suggestions for this transition. The address is DHCSMHMEDI-CALTRANSFER@DHCS.CA.GOV

DMH Community Mental Health Stakeholder Summer 2011

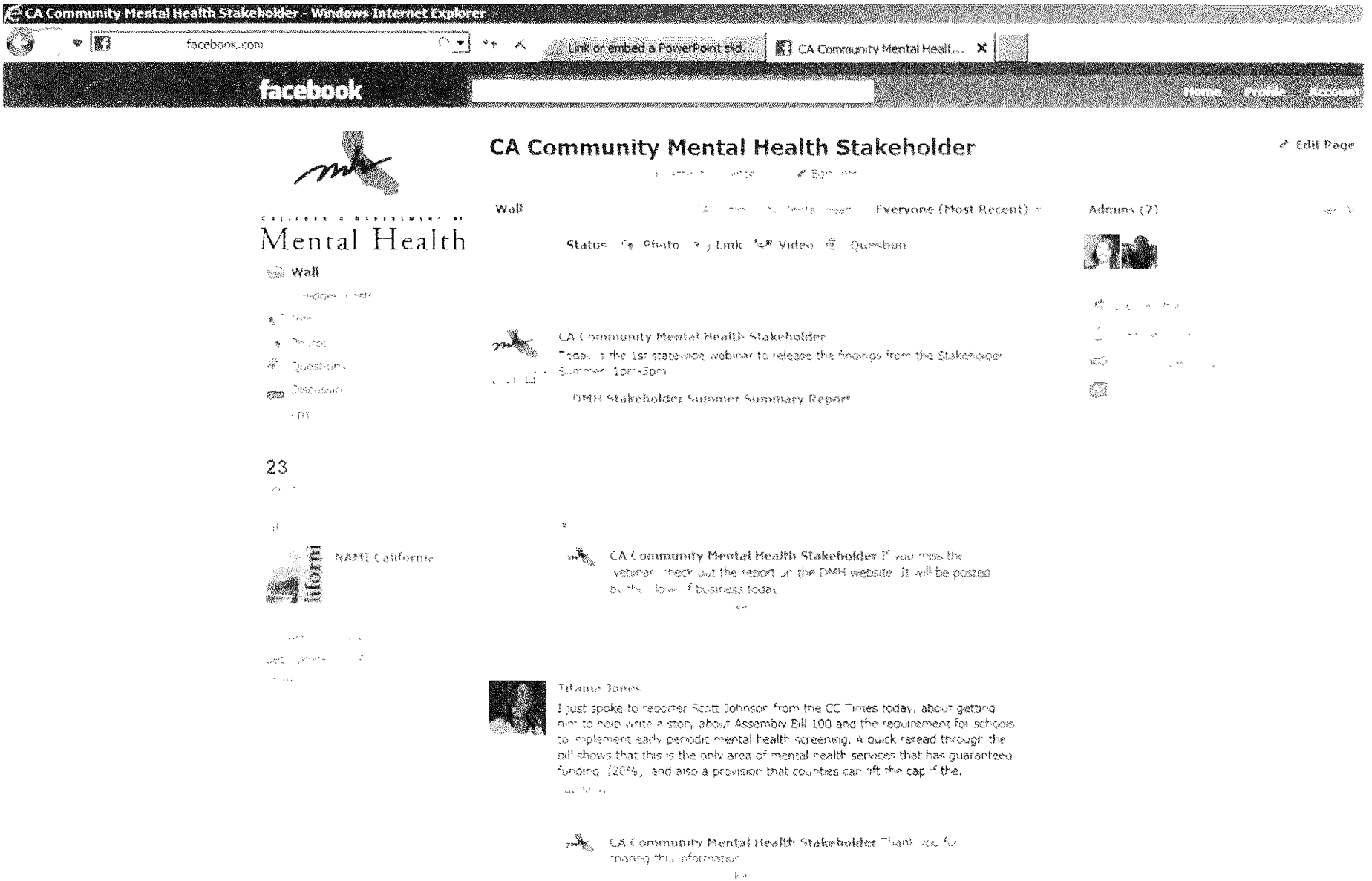
Stakeholder Webinar on September 16, 2011 from 1:00 p.m. – 3:00 p.m.

Stakeholder Summer 2011 Calendar of Events

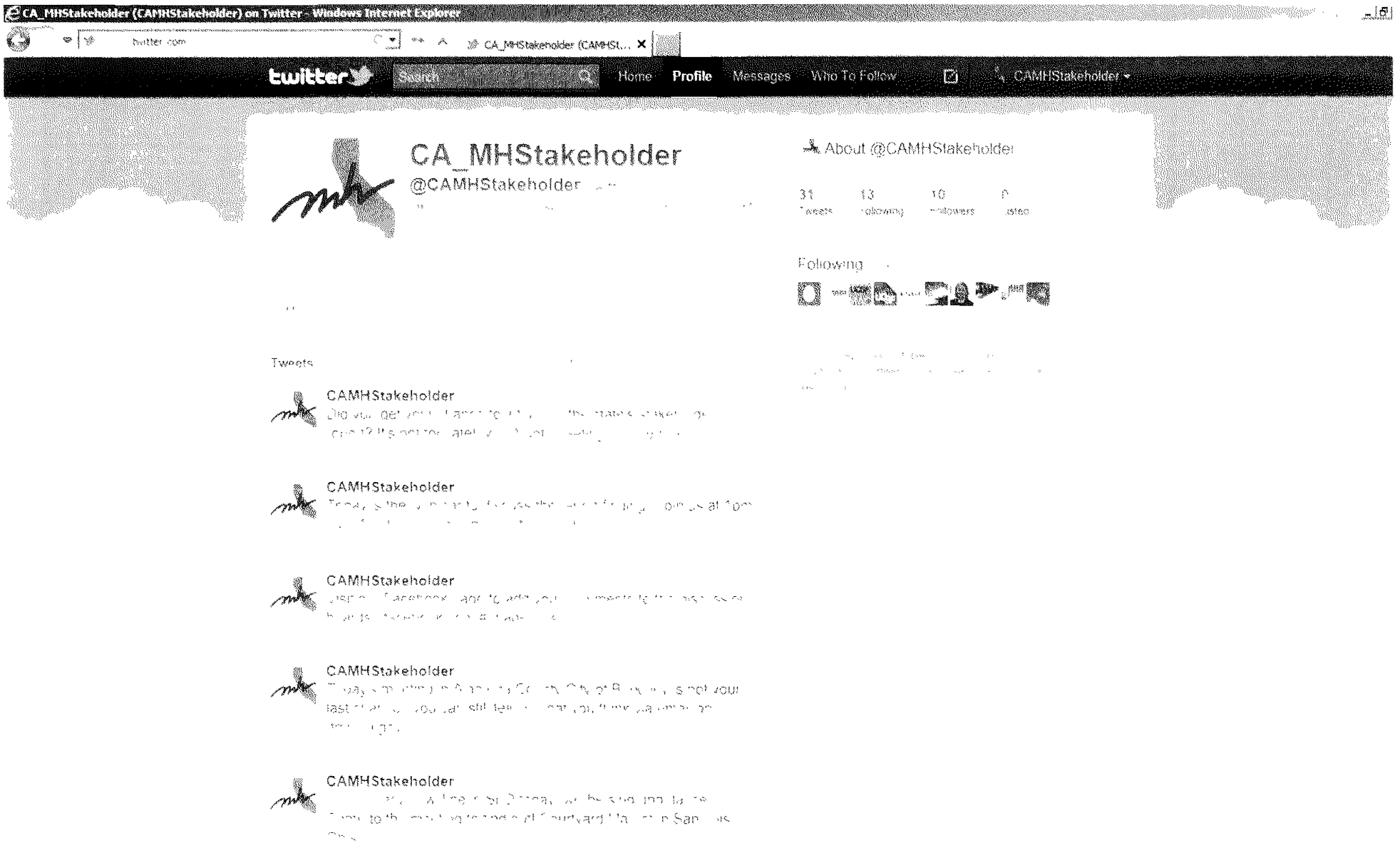
Rose King Comments on Community Services and Supports Requirements

CMHDA Recommendations on State Administration of Community Mental Health (NEW)

DMH Facebook Page
CA Community Mental Health Stakeholder



DMH Twitter Page
CA_MHStakeholder



Appendix XVI

DMH Acknowledgements

Appendix XVII

List of Organizations Participating in the Community Mental Health Stakeholder Process